Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 0 | 0 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Oct. <sup>Day</sup> 2010 3:00 P. M 25 Physician/ Walter Ison Holley Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner N/ABaltimore 2819 Grantley Avenue g. Birthplace (State or Foreign 8. Date of Birth If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number Aug 20 20 941 Funeral Mary Tand 1 X M 2 □ F Yrs. 218–36–4677 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10b. County of Health and Mental Hygiene. "item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State Director Yes 2 No Baltimore Maryland N/A 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number Funeral USA 2819 Grantley Avenue 21215 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Black, White, etc. Armed Forces 1 Never Married 2 Married Yes 2 No Completed by 1 ☐ Yes 2 No Specify: Specify: Black If Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 10th grade College (1-4 or 5+) Supermarket Meat Cutter 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Mary Davis ပ Robert Holley, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2819 Grantley Avenue Baltimore, MD 21215 Sylvia Holley/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 M Burial 2 Cremation 3 Removal from State Woodlawn, MD 11-02-2010 Woodlawn Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home Signature of Funeral Service License 5240 Reisterstown Road Baltimore, MD 21215 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examine attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last by Physician/Medical or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Month Year in the past 12 months? Pregnant at time of death Yes 2 ☐ No ed by the a 1 Yes 2 Lg Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Tunknown 1 Yes hin 24 hours after death.

the Funeral Director: After this certificate has been signing the Funeral director, page 2 should be Completed Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Yes 26. Place of Death (Check only one) 25. Was case referred to m Certificate: To Be examiner? 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 28d. Describe how injury occurred 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death work? 1 Yes 2 No Natural 5 Pending Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Division of Vital Records, To the Hospital within 24 hours a To the Funeral Completed filled

Box 68760

Baltimore, Maryland 21215-0036

32. Registrar's Si filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Clyde Fudge Hagy 10 Medical 2010 8:30 PMM 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 1001 Dellwood Drive Fallston Harford Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Months Days Hours Min **Director** Maryland 83 220-20-7714 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director MD Harford Fallston 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1001 Dellwood Drive 21047 U.S.A within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian rmed Forces?
X Yes 2 \( \square\$ No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married ş 1 X Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: s. Give Year or Dates WW II Specify: 3 Widowed 4 Divorced Completed White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 10 <u>Brazer and Solderer</u> Edgewood Arsenal Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve once. 2 Jacob Thomas Haqy Lena Bertha Lane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1001 Dellwood Drive - Fallston, Maryland (wife) Ann Mary Hagy 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Metro Crematory, Inc. 10/28/2010 | Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. Ci 10 ممه 11750 Belair Road - Kingsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final eso Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence oi). physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 2 No signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page performed Yes 2 death? certificate 1 🗌 Yes 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🗗 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 hours after death.

uneral Director: After this ad filled in by the funeral di After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by th Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature License number address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

## State of Maryland / Department of Health and Mental Hygiene

	1 - State Registrar	-	Cei	rtificate of	Death		Reg. No.	010	21.002
	1. Decedent's Name (First, Middle, La	ist)				2. Date of Dea Month	ath C	010	3. Time of Death
n al	Elsie M. H	Hebert				Octobe	r 24	$20\overset{\text{Ye ar}}{10}$	8:47 pm M
at er	4a. Facility Name (If not institution, give	e street and number)		4b. City, Town,	or Location of Dea	th	4c.	County of Death	
	Transitions Hea	alth Care		Sykes	sville			Carrol1	L
	Social Security Number     6. S			If Under 1 Year Months Days			v. Year)	Con	place (State or Foreign
	130 21 2110	<sup>1□ M</sup> 2 F 87	Yrs.			Nov 1,	192	2	"MS
	Usual Residence of Decedent  10a. State 10b. County	10c C	ity, Town or Lo	cation					10d. Inside City Limits
7			ity, lowil of Lo						1 ☐ Yes 2 🕅 No
ect C	MD Carro	)11			esville			1112	
<u>.</u>	10e. Street and Number			10f. Zip Code	21784		10g. Citi	izen of What Cou USA	intry?
<b>Funeral Director</b>	7003 Macbeth Way								
nue	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13. \	Nas Decedent of f Yes, specify Cul	Hispanic Origin? ( pan, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		<ol> <li>Race - Amer Black, White,</li> </ol>	
by F	1 Never Married 2 Married	1 ∐Yes 2 MNo If Yes, Give	,	I⊡Yes 2√∏ No	Specify:			Specify: W	nite
D D	3 XWidowed 4 Divorced	Year or Dates:		71			150 15	***	
ete	15. Decedent's E (Specify only highest gra	ducation ade completed)	(Give	lent's Usual Occu kind of work done	during most of wo	orking	16b. Ki	nd of Business/Ir	ndustry
Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		00 NOT use retir nvestigat	ive Cler	·k	Soc	ial Sec	urity Admn.
	17. Father's Name (First, Middle, Last	1)	1	1100164		me (First, Middle,			
Be	William H.				Hett			,	
2			401 14 11						
	19a. Informant's Name/Relationship	, ,	I			Rural Route Numbe esville,			p Coae)
	Mr. John E. Heber		1			Date		cation - City or T	awn State
	1 Burial 2 Tremation 3			sition (Name of natory or other pla				-	
	4 □ Donation 5 □ Other (Special	fy) A1			ion   10/			esville	
	21. Signature of Funeral Service Lice	- 11	22	. Name and Addi	ess of Facility HA	IGHT FUN	ERAL	. HOME &	CHAPEL, PA
	Duar L. H.	aight MOUT	64   I	O Box 19	95 Sykesv	ille, MD	217	'84	
	23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dea	th. Do not ent	er the mode of dy	ing, such as cardia	ac or respiratory ar	rrest,		Approximate Interval Between
	Immediate Cause (Final disease or condition	Chran	1c. f	ach	Sun	Marie			Onset and Death
	resulting in death)	Due to (or as a consec	quence of):	,	1				
	Commentation that are divined	Ans	Nexe	2					
ner	Sequentially list conditions, if any, leading to liminediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of).	Δ					
Examine	that initiated events	c. CM	omc	An	enua				
	resulting in death) Last	Due to (or as a consec	quence of):						
ca		<b>d</b>							
Medical							-	_	
	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet		Ectopic pregnar	ICV.		1	23d. Date of deli	
ician/	in the past 12 months? 1 □Yes 2 □No	4 ☐ Pregnant at time of		Other (specify)	СУ			Month	Day Year
Physi	9 Unknown	9 DOUKHOWN							
	Part II. Other significant conditions	contributing to death but not re-	sulting in the ur	nderlying cause g	ven in Part I.	23e. Did to	obacco u	use contribute to	the cause of death?
ğ						101	/es 2[	□ No 3□ Pro	bably 4 Unknown
et						24a. Was	an	24b. Were aut	opsy findings available
Completed by						autop perfo	rmed?	prior to c death?	ompletion of cause of
ပ္	25. Was case referred to medical	T -				1 ☐ Yes	2 No	1 □ Yes	2 No
Be	examiner?	Hospital:	7 FD/0		her:	eath (Check only o			
9	27. Manner death	28a. Date of Injury	ER/Outpatier 28b. Time of	I 3 DOA	4 Lu Nusanig	Home 5 ☐ Resid		6 ☐ Other (Spec	<u></u>
<u>0</u>	1 Stural 5 Pending	(Month, Day, Year)	Injury	Wo	ork? □Yes 2□No	200. 20001001	.on injul	, Journey	
Sa	3 ☐ Suicide 6 ☐ Could not b		nome form str			28f Location (6	Stract on	nd Number or Du	ral Route Number,
Ĭ	4 ☐ Homicide determined		ify)	eet, lactory, office		City or Tov			ai noute muniber,
2	29a, Certifier 1 Certifying Pl	hysician: To the best of my kn	owlodge do-t	a annumed of the	time date and siz	on and due to the	001100/0	) and manner as	etated
dical Certification: Io		miner: On the best of my kn miner: On the basis of examin and manner stated.							

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burla-transit

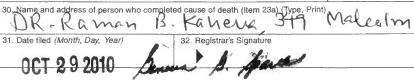
Division of Vital Records, P.O. Box 68760

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year)



DHMH 17 Rev 1/2001

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alest nuntry

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Dorothea Teresa Holladay 12:00 P.™ October 0 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Summit Park Nursing Home Catonsville Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🕱 F Months Days Hours Min. (Month, Day, Year) 09/14/1922 216 14 8160 88 Director Yrs. Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 23a or 28a-f shov 10b. County 10a. State 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits Baltimore Catonsville 1 Yes 2 X No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1502 Frederick Road 21228 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married þ 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Specify: 3 XWidowed 4 ☐ Divorced Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) onday (0-12) College (1-4 or 5+) Secretary Baltimore City Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Charles Joseph Himmel Dorothea Falk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Cruise / Daughter 2728 Westminster Road Ellicott City, Maryland 21043 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 remuster 23a. Pirt 1. Enter the sase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery in the past 12 month 1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Pregnant at time of death 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Tyes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autope, performed 2 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 🗀 No ပ္ 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify, 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending within 24 hours arter voca...

To the Funeral Director: Af 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar

29b. Signature and title of certific

30. Name and address of person who

2 9 2010

completed cause of death

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** ĭ7, ESTHER HARRIS OCTOBER 2010 10:45a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1516 NORTHERN LIGHTS DR. UPPER MARLBORO PRINUE GEORGES If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Numbe 6. Sex 7. Age (In vrs. last birthday) **Funeral** Hours Months Days 1 ☐ M 2 🛣 F 239-18-3785 97 **Director** 4-25-1913 SOUTH CAROLINA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show Director 1XXYes 2 □ No PRINCE GEORGES MD. UPPER MARLBORO 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 1516 NORTHERN LIGHTS DR. 20774 USA by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. 1786 Armed Forces?
1 ☐ Yes 2 🔀 No 1 ☐Yes 2 X If Yes, Give Year or Dates: Exami 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 ☑ Widowed 4 ☐ Divorced **BLACK** Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) -8--0-CIVIL SERVICE VA HOSPITAL item 27 is marked other other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN Be VANDER JACKSON ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHAEL ROBINSON 1516 NORTHERN LIGHTS DR. UPPER MARLBORO, MD 20774 aftimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H
Important: If ites
any Injury or ott 1X Burial 2 Crema PHILA. MEM. PARK 10-23-2010 4 ☐ Donayon FRAZER, PENNA 5 ☐ Other (Specify) Service Licensee JON THAN D. HIBNER Name and Address of Facility EMMETT G. HUNT MEM. CHAPEL, INC 427 E. LINCOLN HIGHWAY COATESVILLE, PENNA 19320 23a Pal 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s pck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition BREAST CANCER **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mont Month Day Year 5 ☐ Other (specify) P.O. signed by the a 1 □Yes 2 PNo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s certificate 2 🖳 No 2 MNo 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Yes 2 **1 | 1** | 10 Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**ORIGINAL** 

DR. IVAN ZAMA, MD 9200 BASIL CT. SUITE 200 LARGO, MARYLAND 20774

32. Registrar's Signature

29c. License number

D10102

29d. Date signed (Month, Day, Year) -25-2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #8 per FH G908 10/29/10 TT Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death O Holler **Physician** Edith Francis Jackson 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Balkmur ourtand vaidens Nuring and Rehabilitation 150 5 Nore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1910 9. Birthplace (State or Foreign Country) **Funeral** 1□M 21 F Days Months Hours 219-20-8141 100 Director 26,2010 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore 1 ☐Yes 2√2 No Directo Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 4117 Sihler Oaks Trail 21117 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Homes Domestic Engineer 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Addie Wilson Martin Francis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: if Item 27 ie m ahy injury or other traum once. 1117 Shiler Oaks Trail Owings Mills, MD21117 Randcy E. Tillery/Grandson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State ` 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial Park 11/4/2010 Arbutus, Maryland 22. Name and Address of Facility
Chatman-Harris Funeral Home
5240 Reisterstown Rd Baltimore, MD 21215 21. Signature of Euneral Service-Licensee 25a. Part1. Enter the dispase, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one pause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) orgestive Mart Physician /Medical Due to ( as a consequence of): Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Dire to (or as a consequence of) Examine that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2[ 1 Tes 2 No 1 Yes Be 25. Was case refer to medical examiner? 26 Plage of Death (Check only one 1 ☐ Yes 2 ☐ No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifie NG 0. Name and address of person who completed cause of death (Item 23a) (Type, Print)
10 Wa Duru CWP 7920 Swtt Quel Nd rath were M

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**Examiner** 

attending physician and for use as the burial-transit

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After thi funeral of

Records, P.O. Box 687667

Division of Vital

To the Hospitel or Attending Physicien:

death.

4 hours after death Funerei Diractor; /

within 24 hours a To the Funerei

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 34007 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 9/12/<u>2010</u> Physician/ Year BRENDA ROSETTA JONES 0347 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CLINTON NURSING HOME CLINTON PRINCE GEORGE'S 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min 1 M 2 KF 4/17/1945 Baltimore, MD Yrs Director 65 578-60-2680 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic event." 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No DC Washington 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 50 P Street SW 20024 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2X No If Yes, Give Year or Dates 1 Yes 2X No Specify: Completed 3 X Widowed 4 ☐ Divorced Specify: Black. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Housewife Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George Young Rosetta Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha Stewart / Sister 1900 C Street NE Washington, DC 20002 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Spec Washington National 9/18/2010 Suitland, Maryland 22. Name and Address of Facility Pope Funeral Homes, P.A. Signature of Funeral Service Lice 5538 Marlboro Pike Forestville, Maryland 20747 rent . Inter the disease or complicate is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, thoo, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or s a consequence f) **Examiner** Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events Duri to for ea a consequence of burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Vunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe ☐ Yes 1 🗌 Yes 2 🔀 No To the Hospital or Attending Physician: Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 🗓 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office juilding, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined Medical Certifying Physician To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exampler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier (Check <u>in</u> the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated The cause of the cause of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signatu Dav. Year 29d. Date signed (Month) K140627 2010

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year,

29 2010

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Ted cause of cleath (Item 23a) (Type, Print) Ave Clinton, MD 20735

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER 269. MARGARET KERMAN-BOYD 2ď°0 2:37 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death FUTURE CARE CHARLES VILLAGE BALTIMORE N/A Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) 1 M 2 F Days Hours (Month, Day, 217-20-3163 82 Yrs. MD Director 24, PRII. 1928 Usual Residence of Decedent 28a-f shov 10b. County 10a. State within 72 hours after death with the Maryland items 23a or 28a-f sho ner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits MD N/A BALTIMORE 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2327 N. CHARLES STREET 21218 USA Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc.
WHITE Armed Forces 1 Never Married 2 Married ō þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates Specify "natural", 3X Widowed 4 ☐ Divorced Completed the Medical Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental tis marked o permit. Page 1 and 2 should be 1. Department of Health and Mental Important: If item 27 is reary injury or other. CYREL RALPH BOYD MARGARET CORRIERRI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 201 E. BALTIMORE ST. 15TH FLOOR BALTO., MD 21202 ARDIE SHAW-GUARDIAN 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) OAKLAWN 10/29/10 BALTIMORE, MD Signature of Funeral Service Licenses 22. Name and Address of Facility CHARLES S. ZEILER AND SON INC 6224 EASTERN AVE BALTIMORE, MD 21224 Part 1 Enter the dise complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transil that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 as the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_ in the past 12 months? Day 1 Yes 21 9 Unknown Pregnant at time of death Month Year Unknown seen signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has ral director, page 2 s autopsy performed? Yes 2 No death? 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes Accident 2 🗌 No Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State State Amend Items 25,27	of Maryland / Depa ,28a-f per me, g Cen	rtment of Health and 1908, 10/29/2010 dificate of Death	d Mental Hygie Ihb Reg	ne . No 2 ()   ()	34009
	Physicia		1. Decedent's Name (First, Middle, Last) Catherine Mildred	Kemmer		2. Date of Death Month	Day Year	3. Time of Death 5:45pm M
3	Medic Examin		4a. Facility Name (if not institution, give street and not Oak Lodge Assisted Li	· ·	4b. City, Town, or Location of De	October ath	4c. County of Death	
Assert The Second	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 H Months Days Hours M		9. Birth	place (State or Foreign
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1	aryland a-f sho fied at	ector	10a. State 10b. County N/A	10c. City, Town or Loc	Baltimore Ci	ty		10d. Inside City Limits  1XXYes 2 □ No
+ - - - -	In the Misa or 28	Funeral Director	10e. Street and Number 1319 Richardson Stree	 et	10f. Zip Code 21230	10g	. Citizen of What Cou USA	
4	leath wil	Funer		cedent Ever in U.S. 13. W	/as Decedent of Hispanic Origin?	(Specify Yes or No-	14. Race - Ameri	can Indian,
036	s after o ral", or i Examin	ρ	1 Never Married 2 Married 1 Yes, G 3 Widowed 4 Divorced Armed F 1 Yes, G 1 Yes, G	s 2 🔀 No live 1	Yes, specify Cuban, Mexican, Pu	erto Hican, etc.)	Black, White, Specify: Wh:	
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اand العالم	snould be filed h and Mental H 7 is marked ot traumatic even	To Be	17. Father's Name (First, Middle, Last)  Ignatz Kloster	-	18. Mother's N Barb	lame (First, Middle, Maid ara Milde	den Surname) enburger	
Mary	and 2 should Health and N tem 27 is ma other trauma		19a. Informant's Name/Relationship (Type, Print) Patricia C. Cosgrove	e / Daughter 1	g Address (Street and Number or 230 Hillcreek R	Rural Route Number, Cit d, Pasadena	y or Town, State, Zip a MD 21122	Code)
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Dipperment of Health and Mental Hygiene. Inpopramt if fiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal fro 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispos cemetery, cremit HOLY Cros	atomi or other place)	Date 200 7/2010	c. Location - City or T Baltimore	
Balti	permit. p Departin Importa any inju once,		21. Signature of Funeral Service Licensee Victor	T Cui	Name and Address of Facility aries L. Steven 501 E. Fort Ave	s Funeral F	Home, Inc.	
			23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on a	caused the death. Do not enter			FID 21230	Approximate Interval Between
	hysician/ Medical			o (or as a consequence of):	farction		1	Onset and Death Minutes
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cuted	nd transit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events  c			N	ER	
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s, P.O	been signed by the should be detached	≦	Part II. Other significant conditions contributing to	death but not resulting in the un	derlying cause given in Part I.		co use contribute to t	he cause of death?
Division of Vital Records, la or Attending Physician; The law requires	has beer	Completed	Pulmonary eub.	ii , Hyperter	Lion	24a. Was an autopsy	prior to co	psy findings available empletion of cause of
	certificate has b		25. Was case referred to medical		26. Place of Death (C	performed 1 🗆 Yes 🔀	No 1 ☐ Yes	2 🗆 No
of Vil	er this co	ᅀ	27. Manner of Death 28a. Date	Inpatient 2 ER/Outpatient e of injury 28b. Time of	28c. Injury at	Home 5 Residence		Assisted Living
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DIVIS		- 1	4 Homicide determined 28e. Place build	e of Injury - At home, farm, streed ding, etc. (Specify) <b>isted Living Fa</b>	·	28f. Location (Street City or Town, St Pasadena, l	t and Number or Rura tate)	Noute Number, Outing Ave.
he Hosc	in 24 ho	Medical	29a. Certiffer (Check 2 Medical Examiner: On the base) one of the Certifying Nurse Practices	asis of examination and/or investig	ccured at the time, date and place gation, in my opinion, death occurre cut coursed at the time date and	d at the time, date and pl	ace, and due to the ca	use(s) and manner stated.
ر ا	1/		29b. Signature and title of certifier  Her W	Physician	29c. License number	١ ,	Date signed (Month, ctober 5,	
	10)		30. Name and address of person who completed cat Benjamin S. Lee, M.D.	use of death (Item 23a) (Type, Pri				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Day Year LOUISE 11:30am™ 10 2010 **Medical** 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death Carroll Carroll Hospital Center Westminster 5. Social Security Number 212–22–0331 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 1 □ M 2 🗓 F Months Hours (Month Day, Ug 26 Year) 925 Country) Aug Director PA Usual Residence of Decedent 23a or 28a-f shov 10a. State 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits by Funeral Director MD Carroll 1 Tyes 2 TNo Mt. Airy 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 2325 Eagle Wood Drive 21771 USA Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 ☐XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 M Widowed 4 Divorced If Yes, Give Specify: White Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) clerical supervisor BGE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ira James Cunningham Ida Mae Braun 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2325 Eagle Wood Dr., Mt. Airy, MD 21771 permit. Page 1 and 2 sh Department of Health a Important: If item 27 is Mr. Les Cunningham (brother) injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 10-26-10 Moreland Memorial Parkville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee ▶ Vauge Haight Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of in jury that initiated events Due to (or as a consequence of): physician and the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death Yes 2 No signed by the a d be detached f 1 Yes 2 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by perlipidemia cate has been sig 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical the funeral director, 26. Place of Death (Check only one) Hospital 2 □ No 은 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Medical Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pendina after death. 2 Accident
3 Suicide Investigation 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by t Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined

5 State Registrar 29a. Certifier

(Check

only one) 29b. Signature and title of certific

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

washington Rd. Westminster, MD

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ AMES KRIFCHIN 0040AN 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death UNIVERSITY OF MAGRANO MEDICAL CENTER BALTIMORE If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country UNK **Funeral** Months Hours Min July 25, 1953 213-64-3866 Director Usual Residence of Decedent 28a-f shov and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shor aumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director MD Harford Jessup 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20794 PO Box 534 USA 72 hours after death 11. Marital Status unk 12. Was Decedent Ever in U.S. Armed Forces?Unk Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 white If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. Specify: 3 - Widowed 4 - Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupationunk 16b. Kind of Business Industryunk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) unk unk Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Sumame) unk ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Detartment of Health at Important: If item 27 is any injury or other trau once. 22 S. Greene St; Baltimore, MD 21201 University of MD Medical Center 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) In State cemetery, crematory or other place, 22. Nome and Address of Facility State Anatomy Board Si nature of Funeral Service licensee Ronald Wade 655 W. Baltimore Street; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SETTLEMIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and the burial-trar resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Day Year should be detached the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ FAILURE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical director, 8 26. Place of Death (Check only one) examiner? 1 Tyes 2 No Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 🗆 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at within 24 hours after death.

To the Funeral Director: After 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation
6 Could not be the Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatur d title of certifier 29d. Date signed (Month. Dav. Year) 1194037160 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMOLEMA KESTLEK S. GREENEST 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ KILBOURNE WALLACE OCTOBER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Glen Burnie Baltimore Washington Medical Ctr. If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Days 214-56-0716 Director MD Usual Residence of Decedent or 28a-f show 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🗓 No Glen Burnie Anne Arundel 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21060 USA 27 Cedar Drive 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Completed by 1 Never Married 2 😾 Married ☐ Yes 2 🔀 No Yes Give Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Machine Shop Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mildred Louise Fields <u>Arthur Lewis Kilbourne</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Cedar Dr. Glen Burnie, MD 21060 Pamela Kilbourne / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State ☐ Donation 5 ☐ Other (Specify) 10/29/10 Glen Burnie, MD Glen Haven Cemetery 22. Name and Address of Facility Signature of Funeral Service Licensee Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy. SE Glen Burnie, MD M01364 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) a. CORALA AFT

Due to (or as a sequence of) ARTERU 465 Medical Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, ESOPHAGEAL CANCER 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an 24b. Were autopsy findings available autopsy performed prior to completion of cause of death? 2 No 2 🗹 N 1 Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation M neral Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined a Puneral Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 10054739 OCTOBER 2742010 ursley M.O. once W

State Registrar

DHMH 17 Rev 7/2009

704

GLEN BURNE MARYLAND

21061

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OAKWOOD

29 2010

31. Date filed (Month, Day, Year)

SUITE

32. Registrar's Signature

			For State Registrar		State of Ma	aryiand		irtment of H tificate of L		, ,	giene Reg. NA	010	34013
М		1	Decedent's Name (F	First, Middle, I	Last)					2. Date of Dea	ath		3. Time of Death
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	/Medic Examin				ive street and number)	2008	1	4b. City, Town, or	Location of Death	000000		County of Death	
)*	LAGIIIII	٠.	2260 Well	ington	Woods Driv	e		Waldor	f			Charles	
المن المن	Funeral		5. Social Security Num		. Sex 7. Ag	e (In yrs. Ia.	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birti (Month, Day			place (State or Foreign ntry)
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	how lat	_	10a. State 10	0b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
	e Ma 3a-f s	cto	Ohio	Be1mor	nt	Be1	laire						1 □ Yes 2 🕅 No
	iff the or 28	Director	10e. Street and Number	er				10f. Zip Code			10g. Citiz	zen of What Cou	ntry?
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	r deg	Funeral	11. Marital Status	-	12. Was Decedent Armed Forces? 1 ☐ Yes 2 🛣	Ever in U.S	. 13. V	Vas Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)		<ol> <li>Race - Ameri Black, White</li> </ol>	
9	afte or it		1 ☐ Never Married		If Yes, Give	40		I∐Yes 2XINo	Specify:	,		Specific -	
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<u>a</u> n		To Be	Pete Clear	5					Anna God	Sev			
3	d 2 should be th and Menta 7 is marked traumatic ev	_	19a. Informant's Name		(Type. Print)		19b. Mailin	g Address (Street			er, City o	r Town, State, Zi	p Code)
Š	ra F		Sue Cianco	one	(Daughter)	)		Silent W					
ē,	一工业产		20a. Method of Disposi					sition (Name of natory or other place		Date		cation - City or T	
Ë	Pages nent of I int: if its iry or o		1. Burial 2 □ C 4 □ Donation 5 I		☐Removal from State			ı. Garden:	i	/2010	Plas	sant Gr	HO Avo
Baltimore, Maryland 21215-0036	permit. Pag Department Important: i any injury o once.		21. Signature of Funer			1102	22	. Name and Addres	ss of Facility			-	ove, on
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2	/Medical		resulting in death)	4	Due to (or as	a conseque	ence of):	111 -0	-/-	71			
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o	The law requires that the death cert te has been signed by the attending age 2 should be detached for use a	Physician/M	1 □ Y <i>e</i> s 2 ☒ N 9 □ Unknown	10	9□Unknown	time or dea	auri SE	Joiner (specify)					
J.	w requires that the d been signed by the should be detached		Part II. Other significa	ant condition	s contributing to death b	ut not result	ting in the ur	nderlying cause give	en in Part I.	23e. Did to	obacco u	se contribute to	the cause of death?
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<u></u>	w rec	lete								24a. Was	an	24h Were aut	opsy findings available
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פֿר	ding Phys n. After this funeral di		27. Manner of De Th		28a. Date of Inju	ry (Year)	28b. Time of Injury	28c. Injur Worl		28d. Describe I			7
<u> </u>	Attendir death. ctor: Af y the fur	atio	2 Accident	5 ☐ Pending investigat	tion	, , , , ,	,u.y		Yes 2 □ No				
DIVISION	r Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine				eet, factory, office		28f. Location (S City or Tox	Street an vn. State	d Number or Ru	ral Route Number,
ב	ital o rs aft ral Di led ir	Çe											
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier (Check only one)	Certifying Medical Ex	Physician: To the best caminer: On the basis o	f examination	ledge, death on and/or in	n occurred at the tir vestigation, in my o	me, date and place ppinion, death occu	, and due to the rred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	o the	Med	29b. Signature and title	e of certifier	and manner sta	ated.		29c. Licens	e number		29d Dat	e signed (Month	Day Yearl
	F 3 F 8		b V	M	00 -			00	C3(	-)	1		4110
			30. Name and address	s of person w	no completed cause of d	eath (Itam '	23a) (Time	Print)	0 21			- 10	0/10
Ц			Krishan Mat	hur, S	50'/20/	L	17	031	C Pl	che	~	260	0646
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34014 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Mary Jane Lulay 7:30 P. M Medical October 0 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Genesis Eldercare Hammonds Lane Baltimore Social Security Number **Funeral** Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🕱 F Days Min. Hours (Month, Day, Year) 05/04/1931 217 26 2571 79 Director Yrs. Maryland Usual Residence of Decedent show 10a. State 10b. County than "natural", or items 23a or 28a-f sho 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No Maryland Anne Arundel Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 613 Hammonds Lane 21225 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 10th Homemaker Own Home Be Department of Health and Mental h Important: If item 27 is marked oth any injury or other transcond 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 George Herzberger Pauline Quasny 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wendy Kester 3834 – 6th Street Baltimore, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 10/26/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ rebrovascula disease or condition resulting in death) Medical Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death, physician and the burial-transi' de M19 Due o (o as a conseque ce of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of **Director:** After this certificate has in by the funeral director, page 2 performed? Yes 2 No death? 1 Yes Be ( Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 4 No ၉ 1 🗌 Yes Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Naturai 5 Pending 1 Tyes 2 Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide within 24 hours after de To the Funeral Directo completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifie Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 000149 30. Name and address of person who completed cause of death (Item 23a) Type, Print)

DHMH 17 Rev 7/2009

Registrar

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32. Registrar's S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death **Physician** Liila Emma October 2010 6:00a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Catonsville Commons Baltimore Catonsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. March 12 Birthplace (State or Foreign Country) Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) . 1922 1 □ M 2 🔽 F 88 Connécticut Director 069-12-6417 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show ral", or items 23a or 28a-f show 1 ☐ Yes 2 No Be Completed by Funeral Director Marvland Baltimore Catonsville 10e. Street and Number 10g. Citizen of What Country? 912 S. Rolling Road 21228 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married "natural", or 1 ☐Yes 2 ☑ No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than 'any Injury or other traumatic event, Item Ma Elementary/Secondary (0-12) 12 College (1-4or 5+) Own Home Homemaker Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Joseph Somogyi Emma Kivalv 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward J. Feehan, Son 7111 Gaither Road, Sykesville, Maryland 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/29/2010 Baltimore, Maryland Metro Crematory, Inc. 22. Name and Address of Facilit Cremation Society of Maryland, 21. Signature of Funeral Service Licensee Amanda Heaston 299 Frederick Road, Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Mulhple Immediate Cause (Final nysician Mydoma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death in the past 12 months? 3 Ectopic pregnancy Month 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □Yes 2 **2** No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 4 Sursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a \*\*Eertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10/28/10 147683 mery Mili 30. Name and addless of person who completed cause of death (Item 23a) (Type, Print) Raymond Miller Smith Ave Suite 203 2835 Balhmore iled (Month, Day, Year) 32. Registrar's Signature State OCT 29 2010 Registrar

DHMH 17 Rev 1/2001

21215-0036

Box 68760.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- For Amend Item 25 per me, g908, 10/29/2010dhb
Rea. No. Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Physician 7:25 A M am 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MIf Under 24 Hrs. 8. Date of Birth Hours Min. Month, Day, Birthplace (State or Foreign Country) If Under 1 Year 7. Age (In yrs. last birthday) **Funeral** Year) 1**Ø**M 2□F Months Days Yrs. june Director rainia Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Kes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2 281 21 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No KYes, Give Year or Dates; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 ☐ XNo Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NQT use retired) College (1-4or 5+) Nare Elementary/Secondary (0-12) abores -H is marked other 18. Mother's Name (First, Middle, Maiden Syrname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be 2 should be fi maker e (ra ပ Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 918 mase Field Rd. Gwyn vak - neice mabre Panna mportant: If item 27 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 20a. Method of Disposition ₽ 9 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 3-2010 DWINGS MILLS, MD Injury ( Tarrison 4 ☐ Donation 5 ☐ Other (Specify) tores 22. Name and Address of Facility 3405 21. Signature of Funeral Service Lipensee Baeto, md. 21229 m. Wallace F.S. Us Approximate Interval Between Onset and Death **Physician** YEAR /Medical Due to (or as a consequence of): Examiner VEN TRICUL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) CERTIFICATION APPROVED BY MEDICAL EXAMINER NEUMONIA sician and burial-trans Due to (or as a consequence of): Physician/Medical attending p for use as t 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 1 ☐ Yes 2 No 5 ☐ Other (specify) ed by the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown CIRRHOSIS Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe CHRONIC 1 ☐ Yes 2 No SUBBURA TOMAS 1 □Yes 2 No of Vital 25. Was case referred to medical examiner?

1 A Yes 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check or one) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ATTENDING ,0 00057216 HY SICIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year) 292010 2. Registrar's Signature

BAAKE, M.D. SAH

mD 2/229

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens 1 - For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 03:40 AM MCCAULE -10 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Muit BACK HEALTH AND REMARILITATION CATONSVIILE BALTIMORE If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 23F Days Hours 218.36.4841 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location 1 Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 4218 AL 3.5-A Funerai Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritat Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Neyer Married 2 ☐ Married 2 No Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 ertment of Heelth and Mental Hyg ortant: If itam 27 is marked other njury or other traumatic event, in 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be TORTMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAROLYN KERR, DAL 20a. Method of Disposition RNE MD · Z 1000 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Buriai 2 □ Cremation 3 □ Removal from State CEDAR HILL CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) CEDARHILL CEMETERY 10-25-10 21. Sign July of Filneral Service License 22. Name and Address of Facility MIERTY FUNERAL HOME Deper Impor MODGLIZ 2001 MOUNTAIN RO. PASADENA, . Part1. Enter the disease, or complications the shock, or heart failure. List only one cause or Approximate Interval Between sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** monty /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) anding physician end use as the burial-translt Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ğ Month Day 5 Other (specify) detached certificete has been signed liector, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes 2 1 No 1 Tyes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Certification: To 2 -110 After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier

The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records, or Attanding Physician: within 24 hours efter deatl To the Funerel Director: completely filled in by the To the Hospital

Maryland 21215-0036

Baltimore,

29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 369

Cotary sille,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) troluick 1009 TURAKHIA

R TURAMI
31. Date filed (Month, Day, Year) 32. Registrar's Signature OCT 29 2010

Registrar DHMH 17 Rev 1/2001

State

(d)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar amend 24a,26 per DR. g908 10d/25/cate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ McClarin 09 2010 Elaine De Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** County of Death Anna Arundel Dod Lecli Social Security Number 6. Sex 1 ☐ M 2 **X** F 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** last birthday, Director N/A Usual Residence of Decedent , or items 23a or 28a-f show 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director Yes 2 No 21 10f. Zip Code 10g. Citizen of What Country? Funeral United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married ģ Yes Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Whit Specify permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatin auch that is a marked of the control of the contr Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Dependent Not Self Supporting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ tim 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15412 Annapolis Road, Bowie, MD 20715 Kim McClarin, Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Atlantic Crematory 08/10/2010 Glen Burnie, MD 4 Donation 5 Other (Specify) of Fure al Service Licensee 21. Si \_\_\_\_ 22. Name and Address of Facility Harman Funeral Service, PA 7221 Grayburn Drive, Glen Burnie, MD 21061 T.Harman 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician, disease or condition resulting in death) houdamnioning Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury Das to for as a consequence of, been signed by the attending physician and should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown 2 No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 🗌 Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has I autopsv perform 2 X No 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be . Location (Street and Number or Rural Route Number, City or Town, State) . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practioner To the best of my knowledge, death of fall the time, date and place, and due to the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) lomen-OB-Gyn 2003 medical PKWY Annapolis MD 21401

DHMH 17 Rev 7/2009

State

Registra

31 Date filed (Month, Day, Year)

OCT 29

egistrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			<b>1 -</b> State of Maryland / Department / Depar	rtment of Health and N tificate of Death	, ,	iene <sub>eg. Ng</sub> 2010 34019
	Physicia	ın/	Decedent's Name (First, Middle, Last)  Celeste Lewis MacMillan		2. Date of Deat October	
	Medic Examin		4a. Facility Name (if not institution, give street and number)  Casey House	4b. City, Town, or Location of Death Rockville	october	4c. County of Death  Montgomery
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2 T F 60 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Oct. 11,	9. Birthplace (State or Foreign Gaunty): ngton, D.C.
	/land f show	tor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loc	ation	<u> </u>	10d. Inside City Limits
	the Mary or 28a- e notifie	Funeral Director	Maryland Montgomery Silver Sp 10e. Street and Number	oring 10f. Zip Code	1	1 ☐ Yes 2 🔀 No
	ath with ms 23a must b	unera	2 Casio Court  11. Marital Status 12. Was Decedent Ever in U.S. 13. W	20906 Vas Decedent of Hispanic Origin? (Spe	point Voc or No	USA
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ▼ No	Yes 2 No Specify:	Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
Baltimore, Maryland 21215-0036	vithin 72 ho jiene. er than "nat the Medica	Completed by	(Specify only highest grade completed) (Give k	ent's Usual Occupation ind of work done during most of work D NOT use retired) Computer Programmer	ing	16b. Kind of Business Industry  Verizion Corp.
/land	d be filed v Mental Hyg arked othe atic event,	To Be	17. Father's Name (First, Middle, Last) Frederick I. Lewis	18. Mother's Nam Fran	e (First, Middle, M ICES Maxwe	
Man	12 should the and the			g Address (Street and Number or Rura B <b>78th Avenue, Hyatts</b> v		
ore,	ige 1 and nt of Hee t: If item		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposicemetery, crem	sition (Name of natory or other place)	Date	20c. Location - City or Town, State
Baltin	permit. Pa Departme Importani any injury once,		4 Donatipn 5 Other (Specify) Ft. Lincoln  21. Signature of Funeral Service Licens e  M01283	n Cemetery : 11/0 Name and Address of Facility F1 7601 Sandy Spring Road	1/2010   .eck Funera l, Laurel,	Brentwood, Maryland al Home, Inc. Maryland 20707
	nysician		23a. Part 1. Enter the disease, or complications that caused the death. Do not ente shock, or heart failure. List only one cause on each line.  Immediate Cause (Final Breast Cancer	r the mode of dying, such as cardiac of	or respiratory arre	est, Approximate Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death)  a. Due to (or as a consequence of):			
p.	uted d ansit	aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or impury that initiated events c.			
~ 09	ite be executed hysician and he burial-transit	dical Examiner	resulting in death) Last  Due to (or as a consequence of):  d.			
Box 687	or Attending Physician: The law requires that the death certificate be executed and dared death. After this certificate has been signed by the attending physician and birector. After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
s, P.O.	ires that th signed by d be detac	à	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.		pacco use contribute to the cause of death?
ecord	e has been ge 2 shoul	Completed			24a, Was a autops perfori	prior to completion of cause of death?
ta H	hysician: The law nis certificate has b I director, page 2 s	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (Check		2 No 1  Yes 2  No
Division of Vital Records,	nding Phys th. After this funeral dir	cate: To	1  Yes 2  No	t 3 DOA CATTER 4 Nursing Ho  28c. Injury at work?  M 1 Yes 2 No		ence 6 🗓 Other (Specify) Hospice ow injury occurred
Divisio	al or Atter s after dea Il Director ed in by the	Certificate:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	et, factory, office	28f. Location (St City or Town	reet and Number or Rural Route Number, n, State)
	To the Hospital or Attending Physwithin 24 hours after death.  To the Funeral Director: After this completed filled in by the funeral di	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death or 2 Medical Examiner: On the basis of examination and/or invest only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death or construction of the basis of examination and/or invest only one)	igation, in my opinion, death occurred a	t the time, date an	d place, and due to the cause(s) and manner stated.
	Vith vith		29b. Signature and title of certifier  2001 Mill 21 CRNP	29c, License number R143201	2	29d. Date signed (Month, Day, Year) 10/27/2010
	V		30. Name and address of person who completed cause of death (Item 23a) (Type, P Deborah Miller 6001 Muncaster Mill Road	Derwood, Maryland 20	)855	
	Stat Registra		31. Date filed (Month, Day, Year)  OCT 29 2010  August 1. Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October Physician/ Marina Gonzalez de Maldonado 2010 12:56р м Medical 4a. Facility Name (if not institution, give street and number) c. County of Death
Montgomery Examiner 4b. City, Town, or Location of Death Washington Adventist Hospital Takoma Park Social Security Numbe (none) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Countr@olombia **Funeral** 1 □ M 2 👺 F Months Days Hours Min. 12/13/1. 14.995 Director Usual Residence of Decedent items 23a or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD Prince George's Hyattsville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Colombia 20783 2116 Hannon Street Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ⊠ Yes 2 □ No Specify: Colombian If Yes, Give Year or Dates Specify: White 3x Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) Emilio Gonzalez 18. Mother's Name (First, Middle, Maiden Surname) 0 Trinidad Hernandez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town State, Zip Code) 2116 Hannon St. Hyattsviile, MD 20783 Nubia M. Gonzalez / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Chesapeake Crematory 1 Burial 2 Cremation 3 Removal from State 10/26/2010 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Filmeral Service 22. Name and Address of Facility Rapp Funeral & Cremation Svcs. 933 Gist Ave. Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Chronic Obstructive Pulmonary Disease Immediate Cause (Final Onset and Death Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of):
Congestive Heart Failure Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Examir Hypertension led by the attending physician and detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Lipodemia Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Yes 2 X No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy Director: After this certificate 1 Yes 2 No ☐ Yes 2 🗓 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tyes 2 🔀 No Other: ဂ္ဂ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural work? 5 - Pending 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check Certifying Nerse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one

Registrar DHMH 17 Rev 7/2009

State

29b. Signatur

Davi Menonnen , MD;

29

31. Date filed (Month, Day, Y

nd address of person who completed cause of death (Item 23a) (Type, Print)

Menonnen , MD; 1600 Carroll Ave Takoma Park, MD 20912

Registrar's Signature

D61307

29d. Date signed (Month, Day, Year) 10/27/2010

10-08169 John Minielli Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

onn wiinieiii		1- For State Registrar	faryland / Depa <i>Cer</i>	rtment of tificate of		and N	/lental H	Re	eg. No. 201	0 34021
Physicia ledical Exami		1. Decedent's Name (First, Middle,Last)  John E. Minielli,	III					2. Date of Deat Month October 2:		3. Time of Death 1930 hrs
		4a. Facility Name (if not institution, give stree 2522 North Edgecombe Circle			4b. City, To		ation of Death		4c. County of D	eath
Funeral Director		5. Social Security Number 6. Sex 1202–54–5985 12 M 2	7. Age (In yrs. Ia	ist birthday) 49 Yrs	If Under Months		Under 24Hrs Hours Min.	_	` 1Fo	Birthplace (State or preign Country)
any		Usual Residence of Decedent  10a. State 10b. County	10c. City	Town or Locat	ion				· - L	10d. Inside City Limits
<b>*</b>	_	MD	1.55. 5.57		imora					1 Ves 2 No
ith the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number			10f. Zip C	ode		10	0g. Citizen of What (	Country?
th the last the last the last the last the last the last last last last last last last last	ä	2522 Edgecomb Circl		t. G	212				United S	States
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatte event, the Medical Examiner must be notified at once.	Funeral		Vas Decedent Ever in U.\$ Armed Forces?  Yes 2 No	S. 13. Wa	es Decedent es, specify	Cuban, Me	xican, Puerto	ecify Yes or No- Rican, etc.)	White, et	merican Indian, Black, c. White
urs aft tural" amine	d by	15. Decedent's Education (Specify only high	es:	16a. Deceden	nt's Usual O	ccupation (	Give kind of w		Specify: 16b. Kind of Busine	
136 hin 72 ho e. than "na	Completed	Elementary/Secondary (0-12) Co	ollege (1-4 or 5+)	_	ost of worki echani		NOT use retir	red)	France	ortation
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Com	17. Father's Name (First, Middle, Last)			echan		lother's Name	(First, Middle, M	Maiden Surname)	DELACION
21215-00 uld be filed wit Mental Hygien marked other e event, the M	Be	John E. Minielli, J					Jeanne	Fowler	<u> </u>	
and 2 should be fitealth and Mental tem 27 is marked traumatic event,	P	19a. Informant's Name/Relationship (Type, P Stephanie L. Miniell	,						nber, City or Town, S	
ore, MI s I and 2 s of Health a If item 27 her traum		20a. Method of Disposition	20b. P	lace of Dispos	sition (Name			Date	20c. Location - Cit	
MOFE Pages   tent of   tent of   tent of   tent other		1 Burial 2 X Cremation 3 Re 4 Donation 5 Other Specify:	movar morn otate	rematory or otl lantic		tory	10/2	29/2010	Glen Burr	nie, Maryland
Baltimore, permit. Pages I at Department of Hee Important: If ite		21. Signature Funeral Service Licensee	Timothy Ha	rmar <sup>22. N</sup>	Name and A	ddress of F	acility Ma	auk & Ya		al Home, Inc.
Physician /Medical		23a. Part I. Enter the disease, or complication failure. List only one cause on each line								Approximate Interval Between Onset and
xaminer	Ì	Immediate Cause (Final disease or condition resulting in death)  A. Hang	ing (or as a consequence of	١٠						Death
en in en		Sequentially list conditions, b.	(or as a consequence or	<i>,</i> .						
	iner	cause. Enter Underlying Cause	(or as a consequence of	):						
cuted ind transit	al Examiner	(Disease or injury that initiated events resulting in death) Last Due to	(or as a consequence of	):						
60, nte be exe hysician a	Medical		NDED							
6876 ertificat iding ph	sician/Me	23b. Was decedent pregnant in the past 12 months?	. If yes, outcome of pregn Live birth Pregnant at time of dea	2 Fe	tal death		ctopic pregna	ncy	23d. Date of deli Month	very Day Year
e te de	Phys	1 Yes 2 No 9 Unknown g	Unknown							
ords, P.O. w requires that it is been signed by should be detact	2	Part II. Other significant conditions contri	buting to death but not re	sulting in the u	underlying c	ause given	in Part I.			e to the cause of death?  Probably 4 Unknown
2 a a 2	Completed		<del> </del>			_		24a. Was a autop perfor	sy prior rmed? deat	
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Vit;	To Be	examiner?  1 ✓ Yes 2 No	i inpatient 2	ER/Outpatient					Residence 6 🗸 0	ther: Scene
	ertification:		ia. Date of Injury :OUND: Oct 25, 2010	28b. Time of In FOUND: 1900 hrs	I	c. Injury at		28d. Describe t Subject han	now injury occurred ged self	
Division ospital or Attendii hours after death. neral Director: /	Certific	3 V Suicide 6 Could not be determined (3	se. Place of Injury - At ho Specify) Multi-Famil		et, factory, c	ffice buildi	·	or Town, S	tate)	r Rural Route Number, City #G, Baltimore, MD
the Ho hin 24 the Fu	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the								
To with com	ĕ		nanner stated.	_		icense nu			29d. Date signed	
		tan Gran -	- Holli	·>	(	D.C.M.E			October 26, 2	010
	Ì	30. Name and address of person who complete Patricia Aronica-Pollak MD.	ted cause of death (Item Assistant Medical E		111 Per	n Street	t. Baltimor	e, MD 2120	1	
St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signatur			5.1.50	.,	-, = 120		
Regist	rar	ULI 60 ZUIU Z	levera G.	Jego aver	_					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 26, Henry John McQueeney, Jr 201°0 10:47 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Timonium Gilchrist Center Social Security Number 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) arch 5,1932 1 XM 2 🗆 F Months Days Hours New York **Director** 027-22-4467 78 March Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director Parkville 1 Yes 2 XNo MD Baltimore 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with tall Hygiene. d other than "natural", or items 23a Funeral 2209 Wilker Avenue 21234 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 Married ፩ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Verizon Technician 4 any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o Henry John McQueeney, Sr Mary Elizabeth Meaney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2209 Wilker Avenue-Parkville, Maryland 21234 Jeanne McQueeney-spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date pulaney (valley 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 🗀 Donation 5 🗀 Other (Specify) Oct.30,2010 Timonium, Maryland Memorial Gardens 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Evans Funeral Chapel and Cremation Services
8800 Harford Road-Parkville, Maryland 21234 L. Mª Fudge Condraé 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) Physician/Medical Box 68760 ending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 10 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician; The law requires Records, ¹VZ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Magner of Dealth 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No. 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident
Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu License number 1010 Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Sinature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month De tober Physician/ 2010 Ray Mann ack C: 39 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harbor Hospital N/A Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/09/1944 **Funeral** 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign 1**▼** M 2 □ F Hours Min North Carolina 214 44 5740 Director 66 Usual Residence of Deceden or 28a-f shov ould be filed within 72 hours after death with the Maryland of Mental Hygiene.
marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director N/ABaltimore Maryland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 406 S. Stricker Street 21223 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) the 10th Dept. Store Warehouse Receiving Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Max Mann Kay Mann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 595 Rt. 3 North Millersville, Maryland 21108 Kay Mann / Mother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 K Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Glen Haven Mem. Park Glen Burnie, Maryland 10/26/2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, occomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between onset and Death Immediate Cause (Final Physician End stage arale disease or condition resulting in death) years Medical Due to (or as a consequence of): Examiner week Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence or) al or Attending Physician: The law requires that the death certificate be executed after death.

I Director: After this certificate has been signed by the attending physician and d in by the funeral director, page 2 should be detached for use as the burial-transit Preumonia Cause (Disease or iinjury week that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical taneous Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ Live Birth 2 Fetal deat
Pregnant at time of death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Thrombout 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of throm bosis 24a. Was an Venou autopsy performed? death? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Other: Certificate: To 1 🗌 Yes 1-XInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) the Hospital of within 24 hours Medical Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD RES OOL October 30. Name and address of persor ho completed cause of death (Item 23a) (Type, Print) MD Pol Harbor Hospital 3001 South Hanover St Orsolu CI ar 32. Registrar's Signatu State Registrar

		4a. Facility Name (if not institution, give street and number) 211 Charles I Boyle Road	4b. City, Town, or Location of Death Queenstown	4c. County of Death Queen Anne's
		<u> </u>		Birth (MM/DD/YYYY) 9. Birthplace (State or Foreig
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last bir	Months Days Hours Min.	Country)
Birector		160-28-7227   1X M 2 F   75	Yrs. June	11, 1935 New York
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town	or Location	10d. Inside City Limits
<b>*</b> .				1 X Yes 2 No
Maryland 28a-f show 1 at once.	ţ	Maryland   Anne Arundel   Edgewa		
e Mar or 28a	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
th the 23a o notifi			21037	USA
ith wi	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or Nif Yes, specify Cuban, Mexican, Puerto Rican, etc.)	<ul> <li>Io-</li> <li>14. Race - American Indian, Black, White, etc.</li> </ul>
er dez or in	Fui	1 X Yes 2 No 3 Widowed 4 X Divorced If Yes, Give Yes OF A. 1057		a v Mhita
rs aft ura!" mine	þ	for Dates: 1934-1937	1 Yes 2 No specify:  Decedent's Usual Occupation (Give kind of work done	specify: White  16b. Kind of Business/Industry
2 hou "nat	ted	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use retired)	Too. Kind of Business/Industry
336 thin 72 h ne. than "n edical E	ple	12 Ma	ster Electrician	IBEW #26
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Montal Hygienei. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	Completed	17. Father's Name (First, Middle, Last)	18.Mother's Name (First, Middle	
21215 uld be file Mental H marked o	Be (	Lawrence Dean Newberry	Jessie Beck Co	usins
2121 ould be fi 1 Mental s marked ic event,	2		b. Mailing Address (Street and Number or Rural Route No	umber, City or Town, State, Zip Code)
MD d 2 shot lith and n 27 is sumation		Pegeen McGlathery/ Daughter 8	3504 Duffers Dell Denton,MD	21629
			of Disposition (Name of cemetery, Date	20c. Location - City or Town, State
MOFE Pages 1: tent of H ant: If it		1 Number 2 Cremation 3 Removal from State Crematical 4 Donation 5 Other Specify:	tory or other place) Kemont ial Gardens 10/29/201	O Davidsonville, MD
Baltimore, permit. Pages 1 as Department of Hes Important: If ite		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Robert E.	Evans Funeral Home
m FP F	i V	KNUTT	16000 Annapolis Road Bow	ie, MD 20715
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do n failure. List only one cause on each line.		
Medical	1 11	Immediate Cause (Final disease a. Multiple Blunt Force Injuries		Death Death
Examiner		or condition resulting in death)  Due to (or as a consequence of):		
	_	Sequentially list conditions, b		
	ine	if any, leading to immediate Due to (or as a consequence of):		
	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	<u> </u>	
and and transi	ũ			
ial iai	Physician/Medical	UNPENDED AMENDED		
Box 68760, e death certificate be the attending physicied for use as the buri	Ne.	IF FEMALE: 23c. If yes, outcome of pregnancy	316. 103.71	23d. Date of delivery
68 certifi	ian	23b. Was decedent pregnant in the past 12 months?  1 Live birth Pregnant at time of death	Fetal death 3 Ectopic pregnancy	Month Day Year
eath c	sic	1 Yes 2 No 9 Unknown 9 Unknown	5 Other (Specify)	
O. B at the d d by the	P.	Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause given in Part I. 23e. Did	tobacco use contribute to the cause of death?
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ds, equire een si	Completed by		24a. Was	s an 24b. Were autopsy findings available
COF law r has b	힐		auto	propry prior to completion of cause of ormed?
Re The ficate	S		1 ✓ Yes	
Division of Vital Records, P.O. Boy With Bospital or Attending Physician: The law requires that the death within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the att completely filled in by the funeral director, page 2 should be detached for	Be	25. Was case referred to medical examiner?	26.Place of Death (Check only one)	
f Vi	မ	1 Yes 2 No	.,	Residence 6 🗸 Other: Scene
	ë	(Month Day Year)		l out of a tree stand
Sio Atten deatl	cati	2 Accident Investigation		
Divi	Ę	Suicide Could not be	arm, street, factory, office building, etc. 28f. Location or Town,	(Street and Number or Rural Route Number, City State) I. Boyle Road, Queenstown, MD
ospits hours nnera y fille	ပ္ပ	4 Homicide	-	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical Certification:	(Check only 1 Certifying Physician: To the best of my knowledge, determinence one) 2 Wedical Examiner: On the basis of examination and/or i	ath occurred at the time, date and place, and due to the cau investigation, in my opinion, death occurred at the time, date	use(s) and manner as stated.  e and place, and due to the cause(s)
To To Com	Med	and manner stated.  29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	-	112 9	2. A O.C.M.E.	October 23, 2010
		20 Market Market	7 (1	
10+1		Name and address of person who completed cause of death (Item 23a)     Russell Alexander MD.    Assistant Medical Examiner	111 Penn Street, Baltimore, MD 21201	
St	ate			
Regist			OCME	

34024

3. Time of Death 1046 hrs

	1 - State Registrar	Certificate of Death	Reg. No.2010 34025
Physician	1. Decedent's Name <i>(First, Middle, Last)</i> Ramanuja I. Narasimhan	2. Date of D Month Octobe	eath Day Year 7 26, 2010 2:45 A M
/Medical Examiner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Funeral	10250 West Lake Drive # 310           5. Social Security Number         6. Sex         7. Age (In yrs. last)	Bethesda st birthday) If Under 1 Year   If Under 24 Hrs.   8. Date of B Months   Days   Hours   Min.   (Month, Days)	irth Day, Year)  9. Birthplace (State or Foreign Country)
Director	223-25-5928	Yrs. Months Days Hours Min. (Month, I November	c 9, 1919 India
ryland how		Town or Location	10d. Inside City Limits
with the Maryland a or 28a-f show the notified at Director	Maryland Montgomery Beth  10e. Street and Number	esda 10f. Zip Code	1 ☐ Yes 2 ☑ No 10g. Citizen of What Country?
23a or st be	10250 West Lake Drive # 310	20817	United States
Ind 21215-0036  be filed within 72 hours after death with the Maryland Ital Hygiene. Id other than "natural", or items 23a or 28a-f show event, I'm Medical Evantinar must be notified at Be Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married  1 □ Yes 2 ☑ No  If Yes, Give	. 13. Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 □Yes 2 ☒ No Specify:	
5-00	3 ☐ Widowed 4 ☐ Divorced Year or Dates:  15. Decedent's Education	16a. Decedent's Usual Occupation	16b. Kind of Business/Industry
21215-00 and within 72 hou ygiene. Per than "natura t, the Medical E. Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+) 5+	(Give kind of work done during most of working life. DO NOT use retired)  Director	Indian Government
Maryland 21215-0036 of 2 should be filed within 72 hours aft th and Mental hygiene.  27 is marked other than "natural", or traumatic event, in Medical Evant To Be Completed by F	17. Father's Name (First, Middle, Last)  R.R. Iyengar		ngar
	19a. Informant's Name/Relationship (Type. Print) Rangamami Narasimhan/ Wife	19b. Mailing Address (Street and Number or Rural Route Num 10250 West Lake Drive #310 E	
Baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Menta mportant: If item 27 is marked any injury or other traumatic evance.		nce of Disposition (Name of metery, crematory or other place) tgomery  Date October 27,	20c. Location - City or Town, State
Baltimor permit. Pages Department of Important: If its any Injury or o	21. Signature of Funeral Service Licensee	matorium, Inc. 2010  22. Name and Address of Facility  Robert A. Pumpbrey Fimeral Ho	•
m =0==0	23a. Part 1. Enter the disease, or complications that caused the death.	Robert A. Pumphrey Funeral Ho 7557 Wisconsin Avenue Bethes	
Physician	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition a Pulmonary H		Interval Between Onset and Death Years
/Medical Examiner	resulting in death)  Due to (or as a conseque		, 50.22
ne d	Sequentially list conditions, if any, leading to immediate cause. Enter Unterlying Cause (Disease or injury	ence of):	
executed an and ial-transit Examiner	Cause (Disease or injury that initiated events c	ence of):	
68760, tificate be executed ng physician and as the burial-transit	d	, 	
O. Box ne death cer the attendir hed for use	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal of the pregnant at time of decent in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	death 3 Ectopic pregnancy	23d. Date of delivery Month Day Year
IS, P. res that the signed by be detacted by by Phy	Part II. Other significant conditions contributing to death but not result		d tobacco use contribute to the cause of death?
cords, w requires been sign should be leted by	Chronic obstructive pulmonary di		Yes 2X No 3 Probably 4 Unknown
Vital Records, sician: The law requires the certificate has been signe rector, page 2 should be completed by	artery disease, Hypertension, Co Heart Failure	aut pe	topsy prior to completion of cause of death?
Vital Fician: The certificate ector, pag	25. Was case referred to medical	26. Place of Death (Check onl)	; 2 ⊠ No
of N			esidence 6 Other (Specify)
/ision ( Attending I r death. setor: After by the funer	2 Accident investigation	Injury Work? 1 ☐ Yes 2 ☐ No	
Division of Vita  To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.  Medical Certification: To Be (	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, street, factory, office 28f. Location City or 7	(Street and Number or Rural Route Number, own, State)
o the Hospi ithin 24 hou o the Funer ompletely fill		rledge, death occurred at the time, date and place, and due to the on and/or investigation, in my opinion, death occurred at the time.	
To the within To the compl	29b. Signature and alle of certifier	29c. License number D53367	29d. Date signed (Month, Day, Year) October 26, 2010
	30. Name and address of person who completed cause of death (Item		
State	Shyamsundar Rajan M.D. 9801 G		ver Spring, Maryland 20902
Registrar	The state of the s	No.	
DHMH 17 Rev 1/2001		ORIGINAL	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#1perpHYS, G908, 10/29/2010, WS
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Virginia Alise Ofenstein Physician/ Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** olumb 2 HOSpita Howa Lounty Genera 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number M 2 XF Virginia **Funeral** Month, Day, Year May 22, 192 Days Hours 225-20-3989 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits or 28a-f show 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Director Columbia 1 ☐ Yes 2 🕱 No Howard Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21045 6336 Cedar Lane #359 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S 11. Marital Status Black, White, etc. Armed Forces 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give ò Maryland 21215-0036 1 ☐ Yes 2 √ No Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Homemaker 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Cora B. Childrey Walter H. Harper 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 446 Winding Lane, Sparta, TN 38583 19a. Informant's Name/Relationship (Type, Print) Linda K. Tirums - Daughter Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/13/2010 Suitland, Maryland Cedar Hill Cemetery 22. Name and Address of Facility Fleck Funeral Home, 1950 Signature of Funeral Service License 7601 Sandy Spring Road, Laurel, Maryland ebec MO1283 23a. Part 1 Enter the diseast, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of 0 Examiner Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician; The law requires that the death certificate be executed for use as the burial-transi physician and that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ Live Birth 2 Fetal death in the past 12 months? Vear Month Day Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed page 2 s death? 1 Yes 2 No certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 000 1 Natient 2 ER/Outpatient 3 DOA 1 🗌 Yes ည 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 X certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Man

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

2010

32. Registrar's Signatura

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 20ÎÖ Charlie Α. Owens, Jr. 11:03a м Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Sex 1 M 2 □ F **Funeral** Age (In vrs. last birthday) 9. Birthplace (State or Foreign Georgia Hours Teb. 2. 1958 52 **Director** 224-94-3375 Usual Residence of Decedent show 10a. State filed within 72 hours after death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medic I Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 XNo Maryland Howard Savage 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8825 Howard Hills Drive 20763 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Yes 2 X No Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) 12 College (1-4 or 5+) Sheet Metal Mechanic Sheet Metal Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental H Charlie A. Owens, Sr. Marilyn Haynes Department of Health and 2 should Department of Health and Innortant: If item 27 is mark any Injury or other traumations. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nadine Owens, Wife 8825 Howard Hills Drive, Savage, MD 20763 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory, Inc. 10/28/2010 | Baltimore, MD 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of FacilitCremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death HEROTIC Physician. terios disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical law requires that the death certificate be 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Box in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day signed by the Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Record need 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate he completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) examiner? 은 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury Division 1 Yes 2 No 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. City or Town, State Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 [ only one certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Physician 6 D 2 address of person who completed cause of death (Item 23a) (Type, Print) RONATO Maryland 20814 8600 Old Georgetown Road, Bethesda, 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 per me, g908, 10/29/2010dhb

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Mildred Marie Purper 09:00AM Medical 2010 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SINAL HOSPITAL OF N/A TIMORE ALTIMORG 8. Date of Birth 7. Age (In yrs. last birthday) 83 yrs. **Funeral** 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 F (Month, Day, Year) 08/06/1927 218 22 5025 **Director** Maryland Usual Residence of Decedent 10a. State 10b. County death with the Maryland an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Anne Arundel Glen Burnie Maryland 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 1058 - 7th Street 21060 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. CHUDAED Yes 2 X No Yes, Give ģ 1 Never Married 2 Married 21215-0036 within 72 hours after 1 ☐ Yes 2 A No Specify. Completed 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Magnes. Elementary/Seconday (0-12) College (1-4 or 5+) Cashier 11th Auntie Anne Pretzels Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leonard Cavey Ida Mitchell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Anthony / Daughter 1058 - 7th Street Glen Burnie, Maryland 21060 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 08/13/2010 Baltimore, Maryland 4 Donation 5 Other (Specify) Baltimore National 21, Sign I rev f F meral Service Licen 22. Name and Address of Facility Gonce Funeral Service. P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) INTRA CRANIAL MEMORRHAGE ew day Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of MEDICAL EXAMINER or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran CERTIFICATION APPROVED BY and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death Year 1 Yes 24 been signed by the sahould be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of page 2 has autopsy performed death? this certificate 2 No 1 Tyes Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Other: မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending work within 24 hours after death.

To the Funeral Director: A 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 | 3 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) RESOOO AUG 08 2010 30. Name and address who completed cause of death (Item 23a) (Type, Print) MOSPI KM 31. Date filed (Month, Day, Year) State 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

AUG 1 1 2010

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			For State Registrar	State of N		d / Depa		Health and	d Mental Hy		gible.	34029
	Division	/	Decedent's Name (First, Middle, Last	et)					2. Date of De	ath	Voor	3. Time of Death
	Physicia Medic		EDNA L. PATTI						OCTOBE	27,	20 <mark>10</mark>	1353 P. M
	Examir	ner	4a. Facility Name (if not institution, give					or Location of De	eath		ty of Death	_
	Funeral		UPPER CHESAPEAKE  5. Social Security Number 6, S			ast birthday)	BEL2 If Under 1 Year		Irs. 8. Date of Bir		HARFOR 9. Birthp	Dlace (State or Foreign
- 1	Director			□ M 2 🗓 F	91	Yrs.	Months Days	Hours M			VIRC	INIA_
	d d	ارا	Usual Residence of Decedent  10a, State 10b, County		T <sub>100</sub> C	y, Town or Lo	nation					0d. Inside City Limits
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	or 28	ä	MD HARFOF  10e. Street and Number	שני		EDGEV	10f. Zip Code			10g. Citizen o	f What Coun	
	s filed within 72 hours after death with the Maryland tal Hygjene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	500 JAMESTOWN COL	RT			2104	40		Į	USA	
5	death items		11. Marital Status	12. Was Decedent Armed Forces	t Ever in U.	S. 13. \	Vas Decedent of I	Hispanic Origin?	(Specify Yes or No- erto Rican, etc.)	14. Ra	ace - America	
<b>₽</b> 8	after Il", or xamil	d b	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 If Yes, Give	<b>]X</b> lo		☐ Yes 2 ☐X		,	Specia	6	
က္ခရိ	hours natura ical E	Completed by	15. Decedent's E		== (	16a. Deced	lent's Usual Occu	pation		16b. Kind of	MUTI	
355	within 72 l giene. er than "r , the Med	텵	(Specify only highest grant Elementary/Seconday (0-12)	ade completed) College (1-4 or	· 5+)	life. D	kind of work done O NOT use retired	t)	vorking			
$\mathbb{Z}_{\overline{2}}$	d with ygien her ti	Be Co		YEARS		PA	ROLL CLE	<del></del>		U.S. (		MENT
and	1 and 2 should be filed within 72 f Health and Mental Hyglene. item 27 is marked other than other traumatic event, the Me	To B	17. Father's Name (First, Middle, Last) WILL IRBY						Name <i>(First, Middle,</i> 'HA DAVIS	Maiden Surnar	ne)	
ڲۣؾ	should be file and Mental I is marked o raumatic eve		19a. Informant's Name/Relationship (7)	/pe. Print)		10h Mailir	ng Address (Street	1	Rural Route Number	er City or Town	State Zin C	2ode)
IΣ	and 2 sh Health ar tem 27 is		SHARON LOMBARDO/D				JAMESTOWN		EDGEWOOI		21040	
(S)	of He of He fitem		20a. Method of Disposition 1 ☑XBurial 2 ☐ Cremation 3 ☐	Damayal from Stat	20b. F	Place of Dispo	sition (Name of	ace)	Date	20c. Location	ı - City or To	wn, State
₩.	. Page tment o tant: If jury or		4 Donation 5 Other (Special		DUI		ALLEY ME		/30/2010	COCKE	YSVILL	E, MD
Baltimor	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other		21. Signature of Funeral Service Licens	● MOO217	-	GANG	and Addr	ess of Facility T	HE JOHNSO	ON FUNE	RAL HO	ME, P.A.
			23a. Part 1. Enter the disease, or com	olications that cause	ed the deat		521 LOCE			OWSON, 1	<u>10 27</u>	286 Approximate
	₽nysician/	,	shock, or heart failure. List only o Immediate Cause (Final	ne cause on each li	ne.	liac	and	1				Interval Between Onset and Death
•	Medical		disease or condition resulting in death)	a. Due to (or as	-		50 1 W				-	
1	Examiner	L.	Sequentially list conditions,	b	che	Der	in	Riguel	rome			
	° ±	Examiner	all any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	Due to (or as	s a consequ	derice oi).		0				
2	ecuter and I-trans	zan	Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to (or as	s a consequ	uence of):				· · · · · · · · · · · · · · · · · · ·	-+	
50	be executed sician and burial-transit	call		d	,	,						
350	ician: The law requires that the death certificate certificate has been signed by the attending phyrector, page 2 should be detached for use as the	Medi	IF FEMALE:	u								
Q ×	h cert tendin r use	an/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 Live Birth	e of pregna	incy al death 3 □	Ectopic pregnar	псу			Date of delive	
% 8 8	e deat the at hed fo	Physician/Med	1 Yes 2 No 9 Unknown	4 Pregnant 9 Unknown		death 5	Other (specify)			N	Month	Day Year
$\leq$ 0	hat the ed by detacl	y Ph	Part II. Other significant conditions of	ontributing to death	but not res	ulting in the u	nderlying cause g	iven in Part I.	23e. Did t	obacco use cor	ntribute to th	ne cause of death?
-3,E	signe Id be	d by	demo	nto					_   1 🗆	Yes 2 No	3 🗌 Prot	oably 4 🗆 Unknown
-20	w requ	plete	•						24a. Was		. Were autor	osy findings available mpletion of cause of
Şĕ	tending Physician: The law leath. or: After this certificate has I the funeral director, page 2 s	Completed							auto perfo 1 □ Yes	rmed?	death?	•
	cian: ] ertifica ector, p	Be	25. Was case referred to medical examiner?	Lloopital:				Place of Death (C				
3	Physic this c	<u>۱</u>	1 ☐ Yes 2 🗷 No 27. Manner of Death	Hospital: 1 Inpa 28a. Date of in		ER/Outpatien	t 3 🗆 DOA		g Home 5 Resi			)
The.	iding Phys th. After this funeral di	cate	1 Natural 5 Pending 2 Accident Investigation	(Month, D	ay, Year)	injury	28c. Inju wor M 1	ryat 1k? ]Yes 2 ☐ No	28d. Describe	now injury occu	rrea	
Sision	Atten er dea ector: by the	Certificate:	3 Sulcide 6 Could not b	28e. Place of Ir			eet, factory, office				ber or Rural	Route Number,
話	tal or irs afte al Dir led in			bullaing, e	tc. (Specify	"			City or Tov	vn, State)		
2	To the Hospital or Attending Physician: The Is within 24 hours after death.  To the Funeral Director: After this certificate his completed filled in by the funeral director, page	Medical		ner: On the basis of	examination	n and/or invest	igation, in my opin	ion, death occurre	ed at the time, date	and place, and d	lue to the cau	use(s) and manner state
	To the within 2 To the Comple	Ž	only one) 3 Certifying Nurs  29b. Signature and title of certifier	e Practioner: To th	e best of m	y knowledge, o	leath occurred at the 29c. Licens		place, and due to the	e cause(s) and r 29d. Date sign		
	F S F O		· Ghe	lu 1	10		Do	20(,32	120	Octo	bocs	27 2010
	4		30. Name and address of person who	ompleted cause of	death (Item	23a) (Type, <u>P</u>	rint)	- WJ0		. 1		1,0010
			George Iscke	rus 50	Dou	pper	hesas	200KQ	Dr. Be	LAG	MC	121014
	Stat Registra		31. Date filed (Mohth, Day, Year)	32. Regist	ar's Sign	arker of	1			1		,
	negistra	-1	001 100 2010 100	-	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October Physician/ Thelma Gertrude Robinson 2010 3:40 P. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 2311 Turner Lane Bel Air Harford 8. Date of Birth (Month, Day, Year) Aug • 29 • 1 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Hours 1 🗆 M 2 🔀 F Maryland Director 1930 Auq. 217-58-8231 80 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 🗌 Yes 2 🖾 No Bel\_Air Maryland Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 72 hours after death with 2311 Turner Lane 21015 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, or P Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 

Widowed 4 □ Divorced Specify: "natural", Black Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Ohantal Hygiene. Important: If ine T23 is marked other than "natur any injury or other traumatic event, the Medical! 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 In and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Clayton White Ardella Lillian Weedon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 st ment of Health a ant: If item 27 is Joyce R. DeWitt / Daughter 2202 Grey Fox Court, Bel Air, MD 21015 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Highview Memorial Gdn 10-30-10 Fallston, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Rd. Abinadon. 23a. Part 1. Edger the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between CANCER Onset and Death Immediate Cause (Final Enysician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (of as a consequence of). sician and burial-transit Exami The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No cate has been signed by the page 2 should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Kn 24b. Were autopsy findings available prior to completion of cause of death? al 24a. Was an performed Yes 2 within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 🗌 Yes 2 🗌 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and tille of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

(c de

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9 2010

9106

32 Registrar's Signatu

LIASSON

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of	Maryland	-	artment of H		Mental Hy	/ U	10	3.403	3
	**		Registrar  1. Decedent's Name (First, Middle,	Last)		Cer	lilicate of L	<u> </u>	2. Date of De	Reg. No.		3. Time of De	
F	Physicia Medic		BRIAN	RID	LEC	7			OCO	25 2	D'/c	83CA	2 м
٠	Examin		4a. Facility Name (if not institution, North West Hosp		per)		4b. City, Town, or Baltimo		th	4c. Coun	ty of Death		
F	uneral				7. Age (In yrs. las		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		th ay, Year)	9. Birthr	place (State or Fi	oreign
D	irector		108-38-8635 Usual Residence of Decedent	TAMZUF	53	Yrs.			May 9,	1957	New	York	
yland	f shov ed at	ctor	10a. State 10b. County			Town or Loc					1	0d. Inside City L 1 √ Yes 2	
ле Маг	or 28a- notifie	Director	Maryland		Bal	timore	10f. Zip Code			10g. Citizen o	f What Cour	- 11	□ No
with th	23a c ust be	Funeral	1913 McCullough	Street			21217			U.S.A			
death	items ner mi		11. Marital Status	12. Was Deced	dent Ever in U.S. ces?	. 13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (S n, Mexican, Puer	pecify Yes or No- to Rican, etc.)	14. Ra	ace - Americ		
after	aľ", or Examir	d by	1 Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced	ied Armed Ford  1  Yes  If Yes, Give  Year or Dat	}		☐ Yes 2 🔀 No				b: Bla		
S hours	"natur dical I	plete		it's Education st grade completed)		16a. Deced	lent's Usual Occup	ation during most of wo	orking	16b. Kind of	Business In	dustry	
ithin 7	than the Me	Completed	Elementary/Seconday (0-12)	College (1-	4 or 5+)		O <i>NOT use retired)</i> ty Worker	•		Pub1	ic Wo	rks	
filed w	d other	Be	17. Father's Name (First, Middle, L	ast)			<u> </u>	18. Mother's Na	ıme (First, Middle		me)		
uld be	's and welfar hygener and artural", or items 23a or 28a-f sho i's marked other than "natural", or items 23a or 28a-f sho raumatic event, the Medical Examiner must be notified at	욘	Arthur Ridley	la (Tara - Orial)		l			e Johnso		Ctata Zin		
and 2 sho	1 7 2		19a. Informant's Name/Relationsh Celia Ridley (S				ng Address (Street a $\operatorname{ple}$ $\operatorname{Ave.}$ ,				State, ZIP	Jode)	
5 7	O <u>v=</u> v=		20a. Method of Disposition 1 X Paris 2 Cremation	3 Removal from		ace of Dispo emetery, cren	sition (Name of natory or other plac		Date	20c. Location	-		
it. Page 1	Department Important: I any injury o once.		4 Donation 5 Dother (S 21. Signsture of Juneral Service L	pecity	Amit		e Cemeter		/3/2010	Amity	ville	, NY	
permit.	Impor any in		Lewel Lewel	y Min		- 1	Name and Address Hempstead 89 Penins	Funera ula Blv	l Home d., Hemp	stead,	NY 11	550	
			23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that cannot one cause on each	aused the death ch line.	. Do not ente	er the mode of dyin	g, such as cardia	c or respiratory a	rrest,		Approximate Interval Betwe Onset and Dea	
	sician Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to k	RCUN or as a conseque	1A	04 /	elva	2		-	Oliset and Dea	7
	aminer			bue to (c	or as a conseque	erice oij.							
D	sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	Due to (c	or as a conseque	ence of):					134		
xecute	hysician and he burial-transit	Еха	that initiated events resulting in death) Last	c. Due to (c	or as a conseque	ence of):							
B pe e	within £4 nous autoreur.  To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical		d			· · · · · · · · · · · · · · · · · · ·						
Sertifica	nding p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		come of pregnan		]			23d. I	Date of deliv	ery	
death	ed for i	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		Birth 2 ☐ Fetal nant at time of de own		Dectopic pregnand Other (specify)			1	Month	Day Yea	ar
at the	ed by the		9  Unknown  Part II. Other significant condition			ulting in the u	nderlying cause gi	ven in Part I.	23e. Did	tobacco use co	ntribute to t	he cause of dea	ith?
Jo, F	an signe	ed by							_	Yes 2 PNo	3 🗆 Pro	bably 4 🗆 Un	iknown
cords, law requires	as bee	Completed							24a. Was	psy	o. Were auto prior to co death?	psy findings ave impletion of cau	ailable use of
r: The	ficate h		25. Was case referred to medical				26 Pi	ace of Death (Ch	1 🗌 Yes	ormed? 2 X No	1 Yes	2 🗆 No	
VILC Iysicia	is cert	To Be	examiner? 1 Yes 2 No	Hospital;	Inpatient 2 🗆 I	ER/Outpatier	Oth	er:	Home 5 Res	idence 6	ner (Specif	D'CE	0
o ing P	After th funeral	l'	27. Manner of Death  1 Natural 5 Dendir	ig .	of injury h, Day, Year)	28b. Time of injury	work		28d. Describe	how injury occu	ırred		
Attendir	ector:	Certificate	2 Accident Investig 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place	of Injury - At hor	me, farm, str	eet, factory, office	163 2 110			nber or Rura	I Route Number	r,
ital or	ral Dir		9		ng, etc. (Specify)					wn, State)			
e Hosp	e Fune	Medical	(Check 2 Medical B	Physician: To the be xaminer: On the bas Nurse Practioner: 1	is of examination	and/or inves	tigation, in my opini	on, death occurred	d at the time, date	and place, and	due to the ca	luse(s) and mann	er stated.
To th	To th comp	_	29b. Signature and title of certifier	12/1		no	29c. Licens	e number	2	29d. Date sign			
			30. Name and address of person	who completed cause	e of death (Item	23a) (Type, F	Print)	35/0		UCY	1	2010	2
			MARRILA	BURM	0 69	30	AVIAT	sim 6	3/rd5	indo	N	2100	61
	Star Registra		31. Date filed (Month, Day, Year)  OCT 2.9		gistrar's Signati	ure	<b>4</b>						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2010 8:13 October Joseph Rogers /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 422 Queenstown Road Severn Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** 1⊠M 2□ F North Carolina July 20, 1917 Director 93 218-03-0634 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if the Medical Examire must be redified at anone. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ☐ Yes 2 X No Anne Arundel Severn Directo MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21144 USA 422 Queenstown Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 ☐ No If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: black 1 ☐Yes 21 No δ 3 ☐ Widowed 4 🖾 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) electronic technician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maud Vines Jake Rogers 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 422 Queenstown Rd; Severn, MD 21144 Anthony J. Rogers 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board 21. Signature of Funeral Service Ronal d 655 W. Baltimore Street; Baltimore, MD 21201 23a. Part : Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sudden **Physician** MUDCARDIAL resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a conse uence of Exami and burial-trar Due to (or as a consequence of) physician the burial Physician/Medical attending p IF FEMALE: yes, outcome of pregnancy
Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗌 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a □Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ HUPERLIPIDEMIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed s certificate has t lirector, page 2 s

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Medical Certification: To after death.

Director: Af
d in by the fur 24 hours aft e Funeral Di letely filled in To the Hosp within 24 ho To the Fune completely fi

		, .	•							
•				4,					24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 ☑ No
25. Was çase refer	red to medical						26. Place	e of Death	(Check only one)	
examiner? 1 ☐ Yes 2 ☑	No	Hospital	1 ☐ Inpatient 2 ☐	ER/Outpatient	3 🗆	DOA	Other: 4 🗆 N	ursing Hom	e 5 Aesidence 6	Other (Specify)
27. Manner of Deal 1 ☐ Natural 2 ☐ Accident	h 5 □ Pending investigation		Date of Injury (Month, Day, Year)	28b. Time of Injury	М	\	Injury at Work? 1 □ Yes 2 □		3d. Describe how injury	occurred
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e.	Place of Injury - At h building, etc. (Speci	ome, farm, stree	t, fact	ory, offi	ice	28	Bf. Location (Street and City or Town, State)	Number or Rural Route Number,
29a. Certifier										and manner as stated.

29b. Signature and title of certific

29c. License number D39166 29d. Date signed (Month, Day, Year)

and manner stated

Name and address of person who completed cause of death (Item 23a) (Type, Print)
ALVIN S. MADARANG, KD 808 LANDMARK DR STE 128

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Cortificate of Death

			For State	State of	Marylan	•	irtment o <i>tificate o</i>			lental Hy		2011	0	3403	3
			Registrar  1. Decedent's Name (First, Middle, L	.ast)		Cer	uncate o	Dea	atti	2. Date of D	Reg. N	dr- U	U	3. Time of Death	_
F	hysicia		Theodore	A	•		Ranl	cin		Month 1 O		Yea		11:14p	v1
	Medic Examin		4a. Facility Name (if not institution, g				4b. City, Tow	n, or Loc	ation of Death	10		c. County of D		11:140	_
mand!			Gilchrist Hos					owsc				Balt	im	ore	
	uneral irector		5. Social Security Number 6. 246–38–8459	Sex 1 M 2 D F	7. Age (In yrs. la 85	ast birthday) Yrs.	If Under 1 Ye Months Da		Jnder 24 Hrs. ours Min.	8. Date of Bi (Month, D	ay, Year)		Birthpl Count	,,	ın
			Usual Residence of Decedent		65	110.				L03_ (	02	25	_	NC_	_
land	shov dat	tor	10a. State 10b. County			y, Town or Loc							10	d. Inside City Limit	s
Mary	28a-1 otifie	irec	MD NA			Balti	.,							1 X Yes 2 🗆 N	lo
ith the	3a or t be r	ral	10e. Street and Number				10f. Zip Coo				10g. C	citizen of What	Count	ry?	
ath w	ems 2	<b>Funeral Director</b>	5712 Jonguil 11. Marital Status	12. Was Deced	lent Ever in U.S	S. 13. V	1 .	212] of Hispar	5 nic Origin? (Spe	cify Yes or No	-	U.S. 14. Race - A		n Indian	_
te 6	, or it	by	1 Never Married 2 Married		2 🗌 No	If	Yes, specify C	uban, M	exican, Puerto	Rican, etc.)		Black, W	hite, e	c.	
21215-0036 within 72 hours after death with the Maryland	tural" al Exa	Completed	¾☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dat			Yes 2					Specify:	В1	ack	
15-	n "na Aedic	nple	15. Decedent's (Specify only highest	grade completed)		(Give k	ent's Usual Oc ind of work do ) NOT use retir	ne during	g most of worki	ng	16b.	Kind of Busine	ess Ind	ustry	
212 vithin	the N	ပိ	8th grade	College (1-	1 or 5+)	ľ	ine Or	•	ator	I	Bure	au of	Eı	ngravino	r
nd filed v	d other	Be	17. Father's Name (First, Middle, Las	t)					Mother's Name						
Very dependent	atic e	မ	Claude Dewitt					Pε	arlie	Mae V	vest	morel	an	<u> </u>	
Mar 2 shou	the neutral western typers.  In marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship Venus Waters-I		^				Number or Rura Road,						
and and	tem 27		20a. Method of Disposition	Jaugircei		1	sition (Name of		1	Daite	_	Location - City			
Page 1	Important: If it any injury or o		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		State C	emetery, crem	atory or other	olace)				-			
Baltimore, permit. Page 1 and	oortar / injur		21. Senature of Funeral Service Lice			oodla 22.	wn Name and Ad rch F	dress of		0/2010	J_WC	odlaw	'n,	Ma	_
ğ e	E # 8	1 1	extrome C	L. Tho	mpsu				est <del>Ave,</del>	Ralti	imor	o Md	2	1215	
			23a. Part 1. Enter the disease, or co shock, or heart failure. List only	mplications that ca	used the death h line.	n. Do not ente	r the mode of o	dying, su	ch as cardiac c	r respiratory a	rrest,	,	1	Approximate Interval Between	
,	sician,		Immediate Cause (Final disease or condition	-a - B1	MOUN	CAN	CW							Onset and Death	
	ledical aminer		resulting in death)	Due to (c	r as a consequ	ience of):								, , , ,	
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ted	ansit	Examiner	Cause. Enter Underlying Cause (Disease or iinjury that initiated events	_											
D. 8	an an rial-tra	EX	resulting in death) Last	Due to (c	r as a consequ	ence of):							1		
cords, P.O. Box 68/60	physician and the burial-transit	edical		d									$\perp$	-	
<b>687</b> ertifica	ding p	/Me	IF FEMALE:	23c. If yes, outc	ome of pregna	ncv									
<b>BOX</b> death of	attend for us	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2  No	1 Live B	irth 2  Feta	Ideath 3 🗌	Ectopic pregn Other (specify				ĺ	23d. Date of Month		y Day Year	
the de	y the ached	hysi	9 Unknown	9 🗌 Unkno											
F.C.	certificate has been signed by the attending trector, page 2 should be detached for use as	by P	Part II. Other significant conditions	contributing to de	ath but not resi	ulting in the ur	derlying cause	given ir	Part I.	23e. Did	tobacco	use contribute	to the	cause of death?	
duires	en sig									1 🕅	Yes 2	!□No 3□	Proba	ably 4 🗆 Unknow	'n
COL law re	as be	Completed								24a. Was	psy	prior	to com	sy findings available pletion of cause of	
ž ž	cate l									1 🗆 Yes	ormed? 2 <b>X</b> ,N	death		□ No	
VItal Kecords, ysician: The law requires	certif	o Be	25. Was case referred to medical examiner?  1  Yes 2  No	Hospital:				Other:	of Death (Check	4		M		hospijo	
of V	eral d	e: To	27. Manner of Death	28a. Date o	npatient 2  finjury	28b. Time of	28c. Ir	jury at	☐ Nursing Ho	me 5 L. Res 28d. Describe		-	ecify)	vaspiy	_
on endin eath.	or: Aft he fun	licat	1 Natural 5 Pending 2 Accident Investigat	ion	, Day, Year)	injury		ork?	2 🗆 No						
DIVISION OF tal or Attending PP rs after death.	irecto n by t	Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	_ 28e. Place of	of Injury - At hou g, etc. (Specify)	me, farm, stre	et, factory, offic	се		28f. Location (		nd Number or	Rural F	loute Number,	
pital C	To the Funeral Director: After this certific completed filled in by the funeral director,		29a. Certifier 1 Certifying Pl	nysician: To the be	-	odeo doeth o	normal at the ti	inno alaba		-l -l 4- 4b			-4-4		
e Hos	e Fun	Medical		miner: On the basis	of examination	and/or investi	gation, in my or	oinion, de	ath occurred at	the time, date	and plac	e, and due to the	ne caus	e(s) and manner sta	ted.
To the	То th	2	29b. Signature and title of certifier	aroc i radionor. K			00 11								
	()		> Quen	(min)			$ \mathcal{D}$	583	<b>6</b> 3		OCF	Uner 2	4	2010	
K	J, , L		30. Name and address of person who		of death (Item	23a) (Type, Pr	int)	1.	63 , ST	711-1	(Cal	no			
			31. Date filed (Month, Day, Year)				i- m	work	, 3/	,,,,,	100				
	Stat Registra		OCT 29 2010	32. Re	gistrar's Signat	ure									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene O Certificate of Death

Reg. No. For State Registrar 3. 3.:04par 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jackie Lee Sims Medical 4a\_Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death ounty of Death Examiner If Under 24 Hrs 8. Date of Birth 7. Age (In yrs. last birthday) 75 Yrs. 9. Birthplace (State or Foreign Social Security Number **Funeral** (Month, Day, Year) V 20 1934 Days Hours Min 1 ▼ M 2 □ F Months 215-30-3592 Director Nov Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho Director MD Carroll Finksburg 1 Tes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21048 4216 Sykesville Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 No Korea Black, White, etc. 1 Never Married 2 M Married ģ Baltimore, Maryland 21215-0036 white 1 Yes 2 No Specify: If Yes. Give Specify: 3 Divorced Completed Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within a sufficient and Mental Hygiene. (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) home improvement painter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Eva (maiden name unknown) Ed Sims permit. Page 1 and 2 shou Department of Health and Important: If item 27 is m any injury or other traum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Esther Sims (spouse) 4216 Sykesville Rd., Finksburg, MD 21048 20a. Method of Disposition
1 ★ Burial 2 □ Cremation 3 □ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lake View Memorial 10-20-10 Sykesville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel Signature of Funeral Service Licensee erbert Paige Houg S & P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician. disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ue to (or as a consequence) ng physician and as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 signed by the attending of the detached for use as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day 2 No 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 1 Yes 2 No 3 Probably 4 Unknown Completed director, page 2 should 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed has death? 1 X Yes this certificate 2 🗆 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 X Yes wher? Other: 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 IDOA မ 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 28b. Time of injury **p** • 27. Manner of Death 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: 24 hours after death. Funeral Director: After 1 1 Natural
2 Accident
3 Suicid 5 Pending work? 1 ☐ Yes 2 🗶 No 10/14/2010 Dislodged Dialysis Vascular Unknown Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Alumber of Bural Route Number, City or Town, State) 7601 Osler Drive Towson, MD 4 Homicide determined building, etc. (Specify)
Hospital Bathroom 29a. Certifier 🔽 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print ran 31. Date filed (Month, Day, Year) State OCT 29 2010 Registrar

			Amend #5, per	se Typ	e or P	rint in	Black I	ndelib	le Ink	. Ens	ure A	II Copie	s Are	e Leg	gible.		
			For State Registrar	SI	ate or	viai yiai		rtificate			and iv	пентаг гту	Reg. No	20	10	34	035
	Physicia	n/	1. Decedent's Name (First, Middle	, Last)		Sh.	ah:					2. Date of De Month	Da	ay OE	Year		of Death
	Medic Examin		4a. Facility Name (if not institution				7712			Location o	of Death	October			2010 y of Death		J AII
	Funeral		Surburb 5. Social Security Number	6. Sex	Hospi		last birthday)	15e	the 1 Year	3 d A	24 Hrs.	8. Date of Bi	rth		gomery 9. Birth	place (Stat	e or Foreign
	Funeral Director		215-02 <del>-9409</del> <b>9499</b>	1 <b>X</b> M 2	2 🗆 F	82	Yrs.	Months	Days	Hours	Min.	No₩onth, 21	y, Y <b>19</b>	27	Cou	Inc	
	land show d at	tor	Usual Residence of Decedent  10a. State 10b. County			10c. Ci	ty, Town or L	ocation									City Limits
	ne Mary or 28a-1 notifie	Direc	Maryland Mo	ntgomer	у	G	aithers	burg 10f. Zip	Code				10a. C	itizen of	What Cou		res 2 X No
	n with the	Funeral Director	531 Skidmore Blvd	•				1 .	20877					USA	<b>.</b>		
(0	er death or iterr niner n		11. Marital Status  1  Never Married 2  Mar	Aı	as Decede med Force Yes 2° Yes, Give	nt Ever in U. s? ☑ No	.S. 13.	If Yes, spec	ify Cubai	n, Mexicar	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)			ce - Amer .ck, White	ican Indian, , etc.	
ğ 0	ours aft tural", al Exar	Completed by	3 ☐ Widowed 4 ☐ Divorced	Ye	ar or Dates	A. 5.	1 40: D.	1 Yes						Specify	ASI		
215-	in 72 ho e. nan "na Medio	omple	(Specify only higher Elementary/Seconday (0-12)	_		or 5+)	(Give	edent's Usua e kind of wor DO NOT use	k done d		t of work	ing			Business I		
d 21	ed with Hygien other th	Be Co	17. Father's Name (First, Middle, L	.ast)			<u>Ma</u>	nager	Т	18. Moth	er's Nam	e (First, Middle			Syste	ms	
ylan	ild be fil Mental narked atic ev	욘	Ram Nath Shahi							Laj	wanti	Vig	-				
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationsl Anil Shahi - Son	nip <i>(Type, Pri</i>	nt)		19b. Mail 531	ing Address Skidmo	(Street a	nd Numbe v <b>d.,</b> G	er or Rura aithe	rsburg,	er, City o MD 20	or Town, . 1877	State, Zip	Code)	
ore,	ge 1 and t of Hea if item or othe		20a. Method of Disposition 1 ☐ Burial 2 🙀 Cremation	3 ☐ Remo	val from St	ate	Place of Disp cemetery, cre	ematory or o	ther place			Date	20c. l		-	Town, State	
altim	mit. Pag bartmen bortant: injury		4 ☐ Donation <sup>2</sup> 5 ☐ Other (5	specify)		Bal	Ltimore 2	Washing 22. Name an				8/2010 Teck Fun	eral			brylan	a ·
m	permi Depar Impo any ir once.		· Jobec V		5	MO128						d, Laure		ary1a	nd 207		
	nysician/	8 9	23a. Part 1. Enter the direas or shock, or heart farure. List o Immediate Cause (Fina	complication only one cause	se on each	sed the dea line.	th. Do not en	0/1/M	e of dying	g, such as	cardiac	or respiratory a	rrest,			Approxir Interval E Onset ar	Between
	Medical Examiner		disease or condition resulting in death)	<b>r</b> a. <u> </u>	Du to (or	as a consec	quenc of):	xuii	0 /4								
		ner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying	b. —	Due to (or	as a consec	quence of):	197051	5 , ,							C THE	eals
D.	executed an and rial-transit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	c	Due to (or	DOVA	Jence of):	<u>r ac</u>	ce a	ent						64	ears
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6876	ertificat ding ph se as th	/Mec	IF FEMALE: 23b, Was decedent pregnant	23c. If	yes, outco	ne of pregn	ancy							234 D	ate of deli	Ven/	
P.O. Box 68760	death c ne atten ed for u	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No	4		th 2 ☐ Fe ntattime of /n		☐ Ectopic   ☐ Other (sp		у					onth	Day	Year
<u>о</u> .	requires that the de been signed by the should be detached	y Phy	g Unknown  Part II. Other significant condition	ns contribu	ting to deat	h but not re	sulting in the	underlying	cause giv	en in Part	l.	23e. Did	tobacco	use con	tribute to	the cause o	of death?
ds, l	equires 1 sen sign ould be	ted b	hypertension									1 🗆	Yes 2				Unknown
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ial B	<b>hysician:</b> The law nls certificate has I I director, page 2 s	Be Co	25. Was case referred to medical examiner?	563	-1-						th <i>(Chec</i>	1 \(\text{ Yes}\) k only one)	2,	Nol	1 L Yes	2 🗌 No	
JĘ.	Physic r this co eral dire	은	1 Yes 2 No  27. Manner of Death	Hospit 28	Ingle Ingle Ing	injury	ER/Outpation 28b. Time		8c. Injury	4 ∐ Ni ⁄at	ursing H	ome 5 Res				fy)	
ion	tending leath. tor: Afte the fun	Certificate:	1 Natural 5 Pendir 2 Accident Investi 3 Suicide 6 Could	gation		Day, Year)	injury	М		? Yes 2□	No No						
Division of Vital Records,	al or At s after c il Direct ed in by		4 Homicide determ			Injury - At h etc. (Speci	ome, farm, s fy)	treet, tactor	/, office			28f. Location City or To			ber or Rur	al Houte Nu	imber,
_	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death certificate be within 24 hours after death.  To the Luneral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but	Medical	29a. Certifier 1 Certifying (Check 2 Medical E	xaminer: O	the basis	of examination	on and/or inve	stigation, in	my opinio	n, death o	ccurred a	t the time, date	and place	e, and di	ue to the c	ause(s) and	manner stated.
	To the within To the comple	Σ	only one) 3 Certifying  29b. Signature and title of certifier		A .	the best of fi	ny knowledge		. License	number		ce, and due to t		ate sign	ed (Month	, Day, Year)	
			* Ungeli	1	ww	of death (lta	m 23a) /Tum	Print)		542			10	25	10		
	10		30. Name and address of person Angela L. Corbin	n, M.D.					Bethe	esda, N	1D 2	0814					
	Stat Registra		31. Date filed (Month, Day, Year) 0CT 2 9 2010	h.	32. Regi	istrar's Signa	Bark	1									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 23, 2010 Charles George Spinner 3:50 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Montgomery Silver Spring 3156 Gracefield Road Apt 209 Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday **Funeral** Sept. 4 Month Hours 1 X M 2 □ F New York 1924 **Director** 074-18-1966 86 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Funeral Director 1 Yes 2 No Silver Spring <u>Maryl</u>and Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20904 3156 Gracefield Road Apt 209 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status ral", or iter Examiner Black White, etc. þ 1 Never Married 2 🕅 Married 1 X Yes 2 No If Yes, Give 1943 Year or Dates 1945 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗶 No Specify: Completed 3 Widowed 4 Divorced White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) alth and Mental Hygiene. 27 is marked other than r traumatic event, the M Elementary/Seconday (0-12) College (1-4 or 5+) Voice of America Radio Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Rosanna Jarrett Charles George Spinner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3156 Gracefield Road Apt 209 Silver Spring, MD 20904 item 27 Jina Spinner/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cematery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 Burial 2 X Cremation 3 Removal from State Washington Crematory: 10/28/2010 4 ☐ Donation 5 ☐ Other (Specify) <u>Laurel</u>, MD 22. Name and Address of FacilityRobert E. Evans Funeral Home 21. Signature of Funeral Service License 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Years shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician/ <u>Alzheimer Dementia</u> Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Physician/Medical Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Live Birth 2 Fetal death
Pregnant at time of death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year To the Hospital or Attending Physician: The law requires that the dewinthin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the acompleted filled in by the funeral director, page 2 should be detached. 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 🗌 Yes 2 🗀 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 \(\sum \) Nursing Home 5 \(\begin{array}{ccccc} \text{Residence} & 6 \sup \text{Other} \end{array}\) Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA Certificate: 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 🗌 Pending 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of my monitoring, death occurred at the time, date and place, and due to the cause(s) and manner stated Centifying Nurse Practioner: To the basis of the house of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Centifying Nurse Practioner: To the basis of my house of the course of the cours (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D24035 <u> 10/28/2010</u> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Eugenio Machado, M.D.

31. Date filed (Month, Day, Year,

OCT 29 2010

DHMH 17 Rev 7/2009

Registrar

32. Registrar's Signature

3110 Gracefield Road Silver Spring, MD 20904

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TITEM#30 perbyR, G908, 107 297 2010, WS

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Evelyn Josephine Simmons Month 12:45 <u>October</u> 2010 Medical 4a. Facility Name (if not institution, give street and number)
206 Careybrook Lane Examiner 4b. City, Town, or Location of Death  $0xon\ Hill$ 4c. County of Death Prince George's Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 6. Sex If Under 24 Hrs. 8. Date of Birth (Month, Day, Funeral 9. Birthplace (State or Foreign 479-18-6225 1 M 2XXF 88 Months Days Hours Min. Iowa **Director** Yrs. /10/1922 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f sho 10d. Inside City Limits Director MD Prince George's Oxon Hill 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 206 Careybrook Lane 20745 USA hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 🙀 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify: 3 Nidowed 4 Divorced Specify: White Completed the Medical 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 72 within 7 College (1-4 or 5+) Elementary/Seconday (0-12) Teacher Education other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) alth and Mental H 27 is marked of r traumatic ever Clyde Emory McDonald Lillie Mae Orange permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic e 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sally Hewett, daughter 1813 Keogh St. Burlington NC 27215 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗆 Burial 2 🖾 Cremation 3 🗀 Removal from State Chesapeake Crematory 10/26/2010 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilitRapp Funeral & Cremation Svcs. 933 Gist Ave. Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death Metastalie disease or condition Medical Examiner resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examine Due to for selection against the cause. Enter Underlying Cause (Disease or linjury that initiated events To the Hospital or Attending Physician; The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): resulting in death) Last signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Pregnant at time of death Month Year page 2 should be detached 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown peen s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has performed? Yes 2 N 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) examiner? Hospital: 2 XNo Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify Director: After this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniury 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier H0058032 30. Name an daddress of person who completed cause of death (Item 23a) (Type, Print) 3720 Upton St. NW Cynthia Williams Washington, DC 20817 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/  $\mathbf{P}^{\mathsf{M}}$ 2010 John Savukinas October 0 4:23 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Suburban Hospital Bethesda Montgomery If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year . Social Security Number 7. Age (In yrs. last birthday) sex 1 X M 2 ☐ F **Funeral** Days (Month, Day August 20 Country)
Massachusetts Min 79 024-26-0227 Vrs Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🛭 No Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 10506 White Clover Terrace 20854 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 If Yes, Give Black, White, etc 1 Never Married 2 Married Completed by 2 No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Sales Rep Marketing Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Savukinas John Rose Sasnauskas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Margaret Savukinas / Wife 10506 White Clover Terrace, Potomac, Maryland 20854 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Holy SepulChre Cemetery Mausoleum October 0 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) Entonbment Burlington, Ontario, 30, 2010 Canada 22, Name and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc.
300 West Montgomery Avenue, Rockville, Maryland 20850-2805 Signature of Funeral Service Ligenses lette Banson M01305 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiorespiratory Arrest disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Severe Sepsis Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause. Enter underlying Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death ate has been signed by the page 2 should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No After this certificate 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) **Division of Vital** Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No 1 🗵 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA Certificate: To 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No s after death. Investigation 6 Could not be Accident Suicide QUUIT INUS 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours Medical 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number MD October 24, 2010 D70241 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Road, Bethesda, Maryland 20814

DHMH 17 Rev 7/2009

State Registrar Shanthi Nadar, M.D

31. Date filed (Month, Day, Year) OCT 29 2010

10/23

John

32. Registraris Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death Physician/ October 24, 2010 Adam Edward Skoloda 10:30am M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6040 Augustine Avenue Elkridge Howard . Social Security Number 9. Birthplace (State or Foreign Country) D A If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth Min June 27 1 X M 2 - F Year 1922 88 Director PA 177-16-7375 Usual Residence of Decedent or 28a-f show ıral", or items 23a or 28a-f shor Examiner must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director MD Howard Elkridge 1 🗆 Yes 2 🛣 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21075 6040 Augustine Avenue hours after death 12. Was Decedent Ever in U.S.
Armed Forces?

1 ☑ Yes 2 ☐ No WWII 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", 1 ☐ Yes 2 🕅 No Specify: Specify: White Completed 3 X Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) within 72 permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Mea once. Elementary/Seconday (0-12) College (1-4 or 5+) ARMCO Steel crane operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Skoloda Sophia Smolko 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6040 Augustine Ave., Elkridge, MD 21075 Mrs. Diane Day (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place 10-28-10 ake View Mem. Park Sykesville, MD 21. Signature of Funeral Service License 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician End stage disease or condition Medical resulting in death) Examiner Eequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-trans Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Live Birth 2 Live Ferancies.

Pregnant at time of death in the past 12 months? Day Year 9 Unknown 9 Unknown rate has been signed by page 2 should be detach Part II. Other significant conditions control byting to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 KResidence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at ↑★ Natural injury 5 Pending 2 Accident 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 only one) 29b. Signature and title of certifier October 25, 2010 Lappans Rd Boonsboro MD 21713

Ø

Registrar

31. Date filed (Month, Day, Year) 292010

(Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 11.30 M Medical Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner County of Death 586 1 DOOD Age (In yrs. last birthday) If Under If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🗆 M 2 🗓 Months Min. 220-20-612 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show idical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Centreville MD Queen Annes 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21617 111 Chesterfield Avenue 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 K Yes 2 No 1943-Black, White, etc. 1 Never Married 2 Married þ hours after Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: White 3 Widowed 4 🙀 Divorced Completed 1946 Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Seconday (0-12) 12 College (1-4 or 5+) homemaker own home Be 17. Father's Name (First, Middle, Last) .. Page 1 and 2 should be filed tment of Health and Mental H tant: If item 27 is marked ot 18. Mother's Name (First, Middle, Maiden Surname) ည Andrew Maurice Eastwick Estelle Stinson other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Caroline Seaton-Lyon daughter 111 Chesterfield Ave; Centreville, MD 21617 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board 21. Sign 655 W. Baltimore Street; Baltimore, MD 21201 23a. Par 11. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shirts, or heart failure. List only one cause on each line. Interval Between Immediate ause (Final disease or condition resulting in death) Onset and Death Physician/ ) Medical Due to (or as a consequine Examiner Sequentially list conditions if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury Due to (or as a consequence of): Examir burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical The law requires that the death certificate be 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day ned by the a P.O. been signed to should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Tyes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? Yes 2 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, of Vital Hospital or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: မ 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury work?
1 Yes 2 No 5 Pendina Division Accident Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the Pwithin 24 only one 29b. Signature and title 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mo -ynwood 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 292010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ RAYMOND SITEMER /0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BATTIMORE CENTER N/A UNIVERSITY OF WALYCAND MEGREAT 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) (ar 10, 1945 Maryland Months Hours 1X M 2 . F Director 219-40-4861 Mar Usual Residence of Decedent should be filed within 72 nours and and Mental Hygiene.

I is marked other than "natural", or items 23a or 28a-f show it marked other than "natural", or items 25a or 28a-f show are marked other than "hedical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County Director 1 X Yes 2 No Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21230 2306 Sidney Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 XYes 2 No
If Yes, Give Black, White, etc. 1966 1969 ≥ 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Heating & A/C Technician other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Elsie C. Toomey James H. Shewell Sr. permit. Page 1 and 2 should be Department of Health and Men Important: If Item 27 is marke any injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2306 Sidney Avenue Baltimore, Maryland 21230 Ethel Shewell, Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State Baltimore, Maryland Metro Crematory Inc. 10/28/10 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licen Thomas Gregor Cremation Society Of Maryland, 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final SETTLEMIA Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner PREUMINIA Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Exami attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Medical P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery Physician/ 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Pregnant at time of death JYes 2 ☐ No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PULMONARY EUROCUS 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available 24a. Was an autopsy LUNG CANCER e Hospital or Attending Physician; The law I 24 hours after death. e Funeral Director: After this certificate has t leted filled in by the funeral director, page 2 sl prior to completion of cause of death? performed 2 No 1 Yes 25. Was case referred to medical examiner?
1 \( \sum \) Yes 2 \( \sum \) No Division of Vital 26. Place of Death (Check only one) Be Other: Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Deal 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one) 29d. Date signed (Month, Day, Year) 29b. Signature and fitle of certifie 1194037960 10 10

State Registrar BATIMORE WO ZIZGI

S. CREENE ST

32. Registrar's Sig

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. per FH 6908 10/29/10 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 10 22 2010 10:35A <sup>™</sup> Alean Smith /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/ABaltimore Keswick Multicare 8. Date of Birth (Month, Day, Year) 01/29/1940 Birthplace (State or Foreign
Country) Social Security Number 7. Age (In vrs. last birthday, **Funeral** Months Days Hours Maryland 1 M 2 F 70 Director 220-38-6066 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County r 28a-f show notified at 1X Yes 2 No Director N/A Baltimore MD 10f, Zip Code 10a. Citizen of What Country? 10e. Street and Number ms 23a or 7 U.S.A. 21211 40th Street 700 W. Pages 1 and 2 should be filed within 72 hours after death v nent of Health and Mental Hyghene. The man and the 27 is marked other than "natural", or items 23a ant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner must ury or other traumatic event, the Medical Examiner must Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? + 過半es 2 图 No If Yes, Give Year or Dates: 14. Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Black Completed by 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled N/A12th Grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Newman John McNeil ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2911 Clifton Ave., Baltimore, MD 21216 Bernard Conaway(son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. Burial 2 ☐ Cremation 3 ☐ Removal from State 10/28/10 Arbutus Cem. Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) <sup>22</sup>Josephdom of Brown Jr. Funeral Home 2140 N. FUlton Ave., Baltimore, MD 21. Signature of Funeral Service Licenses PA 21217 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ediate Chise (Final **Physician** annous disease or condition resulting in death) /Medical (of as a consequence of): Examiner Cardialasa NEWSIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or a a consequence of): Division or Vital Records, P.O. Box 68760, MYNOVICE Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Day Month 1 ☐ Yes 2 ☑ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed Yes 2 No 1 | Yes 25. Was case referre o medical examiner? 26. Place of Death Check onl one Be Other: Hospital: 2 7 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🔲 Inpatient 1 ☐ Yes Certification: To 27. Many r of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? After 1 (Month, Day Year) injury 5 Pending investigation 1 ☐ Yes 2 ☐ No М 2 Accident Director; 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 □Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined n 24 hours after o 4 🗌 Homicide 1 Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of contifier D0064788 person who completed cause of death (Item 23a) (Type, Print) 30. Name and address EUTAW ST. SUITE 301. BALTIMORE MD 2120 821 N. 32. Registrar's Signature (Month, Day, Year)
OCT 2 9 2010 31. Date filed State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 10/15 Hedwig J. Stopa Physician/ 9:25pm Medical 4a. Facility Name (if not institution, give street and number)
Stella Maris 4b. City, Town, or Location of Death **Timonium** 4c. County of Death
Baltimore Examiner Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 152-07-1495 1 M 2 K Months Days Hours Min 90 *5*7977920 Director NJ Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location with the Maryland notified at Director MD Baltimore Timonium 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be 2300 Dulaney Valley Road Funeral 21093-2738 USA hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Yes 21215-0036 white 1 Yes XX No Specify If Yes, Give Year or Dates Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) Elementary School Teacher Education Be Baltimore, Maryland 17. Father's Name *(First, Middle, Last)* Wandalin Juchniewicz Mother's Name (First, Middle, Maiden Surname)
 Emilia Dziezyc 2 19a. Informant's Name/Relationship (Type, Print)

Edward Stopa / Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 65 Hamilton Drive, East Greenwich RI 02818 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Holy Cross Cemetery 10/23/10 NJ North Arlington, 4 Donation 5 Other (Specify) Doda, Jr22 Name and Address of Facility Charles L. Stevens Funeral Home, 1501 East Fort Avenue, Baltimore 21. Signatur of Funeral Service Licensee Victor P. any in 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ mentio Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) 2010 Cause (Disease or inijury the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Completed by Physician/Medical OCTOBER 15, that the death certificate be Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year 5 Other (specify) Day been signed by the sahould be detached 1 Yes 2 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law page 2 autopsy performed? Yes 2 No has death? certificate 2 No STOPAwithin 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 No Hospital: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) HEDWIG 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural injury 5 Pending Investigation Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stateu.
2 Medical Examiner: On the basis of examination and or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature and title of certifie 2010 ress of person who completed cause of death (Item 28a) (Type, Print) 2300 DULANEY VALLEY ROAD ERNESTINE WRIGHT M.D.TIMONIUM, MD 21093 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

10-08030 Robert Smith Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1. For State    Certificate of Death   Reg. No.   Reg. No.	4044
Physicia Medical Examin		Toloro Doloro-L God-Llo To-	e of Death 55 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 1820 Spence Street Apt. 113  Baltimore	
Funeral Director		5. Social Security Number  6. Sex  1 X M 2 F  7. Age (In yrs. last birthday)  7. Age (In yrs. last birthday)  1 Yrs.  1 Under 1 Year If Under 24Hrs.  1 Under 24Hrs.  1 If Under 24Hrs.  2 If Under 24Hrs.  3 If Under 24Hrs.  3 If Under 24Hrs.  3 If Under 24Hrs.  4 If Under 24Hrs.  5 If Under 24Hrs.	(State or
w any	F	MD 17/2	nside City Limits
aryland 8a-f shov	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	Yes 2 No
ith the Ma		1820 Spence Street, #113 21230 USA  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Bace - American Indi	
after death w	by Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced or Pates: 1 Yes 2 No specify: Specify:	ian, Black, ite
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+) 12  College (1-4 or 5+) Warehouse worker  16b. Kind of Business/Industry warehouse worker  manufacture  To be dent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  warehouse worker  manufacture	cturing
215-0 be filed w ntal Hygid rked othe	္က မ်ို	17. Father's Name (First, Middle, Last)  John R. Smith, Sr.  18. Mother's Name (First, Middle, Maiden Surname)  Doris May Phillips	
MD 21 12 should 14 should Me 157 is ma 177 is ma 10 matic ev	2	19a. Informant's Name/Relationship (Type, Print) Rochelle Hankins / Daughter  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co 7728 West Drive, Glen Burnie MD 21060	de)
imore, Pages 1 and ment of Heal tant: If iten or other tra		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:  20b. Place of Disposition (Name of cemetery, crematory or other place)  Ardent Crematory  10/28/2010 Hanover MD	itate
Ball permit Depart Impor injury		22 Signature of Funeral Service Licensee Victor P. Doda  22 Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore MD 2123	30
Physician Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart  Approx	oximate Interval reen Onset and Death
"		Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):  Due to (or as a consequence of):	
·	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):	
e execute cian and rial - tran	Medical	M AMENDED X AMENDED 220 27 280 f por ME c010 12/7/10 FF	
		# las noted, 23a,27,28a-f,per ME g910 12/7/10 TT  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown 0 Unknown 0 Unknown 1	Year
O. BC nat the de ed by the edached for		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause	se of death?
ds, P equires the equires the equipment of the equilibrium of the equi	ered by	1 Yes 2 No 3 Probably 4  24a. Was an 24b. Were autopsy fin	
Division of Vital Records, P.O. Is a or Attending Physician: The law requires that the start death.  Al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	e completed	autopsy performed? death?  1 ✓ Yes 2 No 1 ✓ Yes  25. Was case referred to medical 26.Place of Death (Check only one)	on of cause of
Physician Physician Trihis certi	2	examiner? 1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other 4 Nursing Home 5 Residence 6 V Other: Scene	
ion of tending leath. lor: Afte the funer		27. Manner of Death  1 Natural 5 Pending Investigation Investigation  28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?  1 Accident Pending Investigation 28b. Time of Injury 28c. Injury at Work?  1 Yes 2 No unk  28d. Describe how injury occurred unk	
Divis pital or At pours after d eral Direct filled in by	Certification	3 Suicide 64 Could not be determined (Specify) Tesidence (Specify) Tesidence 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Spence 113 Baltimore, MD	Number City St Apt
To the Hos within 24 h To the Fun	<u>ਦ੍</u>   '	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	s)
To with To con	E -	29b. Signature and title of certifier  29c. License number  O.C.M.E.  October 20, 2010	Year)
		30: Name and address of person who completed cause of death (Item 23a)  Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
Stat Registra	-	31. Date filed (Month, Day, Year)  OCT 2 9 2010  32. Registrar's Signature	

State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 24. October Ž&10 8:55 Рм Twigg Christine Laura Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Bethesda Suburban Hospital Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Yea 1 🗆 M 2 😾 F Months Washington, D.C Director 579-20-2835 87 923 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 No Potomac Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20854 United States 2 Lawngate Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: Specify: White "natural", 3 X Widowed 4 ☐ Divorced Completed the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within 73 Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Thomas Fannie Mark Gardella 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 519 Rosebush Lane, Rockville, Maryland 20850 Linda C. Young / Daughter item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date permit. Page 1
Department of I
Important: If it
any injury or o 1 🗆 Burial 2 ី Cremation 3 🗀 Removal from State October 0 Bethesda, Maryland Montgomery Crematorium, Inc 4 Donation 5 Other (Specify) 2010 Signature of Funeral Service Ligensee Robert A. Pumphrey Funeral Home/Rockville, Inc. M01305 20814-3501 0 300 West Montgomery Avenue, Rockville, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate 3 Interval Between Onset and Death Immediate Cause (Final ARDIOP-Imman Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Metabolic Acidos Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examin and I-transit Cause (Disease or linjury that initiated events te Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical ocardia requires that the death certificate be Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Day 4 ☐ Pregnant at time of death g ☐ Unknown 9 Unknown After this certificate has been signed by funeral director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 XYes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Hospital or Attending Physician: The 2  $\square$  No **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) xaminer? Hospita Other: 2  $\square$  No ျပ 1 Ninpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) iniury work? 1 Natural 2 Accident 5 Pending 2 No Investigation 2' \to \text{Accident} 3 \to \text{Suicide} 4 \to \text{Homicide} within 24 hours after death

To the Funeral Director;

completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F only one) 29b. Signatur 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mel 31. Date filed (Month, Day, Year) 32. Registrar's Sig State 29 Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 27. 2010 Year October 9:25 Suzanne Becker Tobey Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Manor Care - Potomac Potomac Montgomery Social Security Number . Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🛛 F Days Hours Min. October 2 Ohio Director 88 272-20-3514 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location Director 10d. Inside City Limits Maryland 1 X Yes 2 No Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20815 6124 Western Avenue United States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced Specify: White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home <u>Homemaker</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Fred John Becker Margaret Moeser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret L. Tobey/Daughter 6124 Western Avenue, Chevy Chase, Maryland 20815 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Montgomery
Crematorium. Inc. 1 🗌 Burial 2 💢 Cremation 3 🗌 Removal from State October 0 4 ☐ Donation 5 ☐ Other (Specify) 2010 Bethesda, Maryland Robert A. Pumphrey Funeral Home, Chevy Chase, Inc. 21. Signature of Funeral Service License Hauan M. M01530 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ ever 9240 disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sprok Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to lor as a conse uence of Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death Month Day Year 9 Unknown After this certificate has been signed by funezal director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by pertension Completed 1 Yes 2 No 3 Probably 4 Unknown obstructive gulmonary disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 Yes 2 No Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier Leftifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0054566 10/27/10

State Registrar 9801 Changia

32. Registrar's Signature

Annu #117 Silverspring

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sunithor Bhogavilli

31. Date filed (Month, Day, Year)
OCT 2 9 2010

10-08076 Barbara Tucker Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

arbara Tucker		1- For State	te of Maryland	-	artment of		nd Mer	ıtal Hy		201	0 340	147
Physicia		Registrar  1. Decedent's Name (First, Middle,L	Last)		tinoate c.			$\overline{}$	2. Date of Dea		3. Time of Dea	ath
Medical Exami	ai ii		Barbara Llo	vd T	ucker				Month October 2	Day Year 21, <b>201</b> 0	1047 hrs	i
		4a. Facility Name (if not institution, s 103 Timber Brook Lane	give street and number)		1	4b. City, Town, Gaithersb		of Death		4c. County of D Montgome		
Funeral				e (In yrs.	last birthday)	If Under 1 Ye		der 24Hrs.	8. Date of Bi	irth(MM/DD/YYYY) 9	9. Birthplace (State o	or
Director	. ]	i i	1 M 2 X F	71	Yrs		ays Hour	rs Min.	Latabe	r 11,1939	oreign Country) Louisia	~ ~
	, }	Usual Residence of Decedent							OCTODE	TILTIAN		
w any		10a, State 10b, County		10c. City,	, Town or Locati	ion					10d. Inside Cit	·
Maryland 28a-f show d at once.	ខ្ន	Maryland Mont	gomery	<u> </u>		Ga 10f. Zip Code	aither	sbur	g	10a. Citizen of What		. INO
th the Maryland 23a or 28a-f sho notified at once.	Director			"		TOT. ZIP Code			Ι'	3	,	
with the s 23a e notif		103 Timbert 11. Marital Status	brook Lane		I.S. 13. Wa	as Decedent of F	2087 Hispanic Ori		ecify Yes or No		ed States American Indian, Blac	ck.
leath v	Funeral	1 Never Married 2 Marri	ied Armed Forces?			es, specify Cub				White, et		urt,
after d	by Fi	3 Widowed 4 X Divorce	ced If Yes, Give Year	ZI NO	1	Yes 2X N	No specify.	<i>c</i>		Specify:	White	
1215-0036 Id be filed within 72 hours after death with the Maryland fental Hygiene. narked other than "natural", or items 23a or 28a-f she event, the Medical Examiner must be notified at once	9	15. Decedent's Education (Specify	y only highest grade com		16a. Deceden during m	nt's Usual Occup	oation (Give	kind of we	ork done red)	16b. Kind of Busine	ess/Industry	
36 hin 72 h e. than "u	plet	Elementary/Secondary (0-12)	College (1-4 or	5+)							_	
5-00; led withi Hygiene, other ti	Completed	17. Father's Name (First, Middle, La	ast)		Uper	cations				Health Maiden Surname)	Insurance	<u>e</u>
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be C		Edward Patt	on						or Green		
( ) Z < E 0		19a. Informant's Name/Relationship	o (Type, Print )		19b. Mailing	Address (Str	eet and Nur	mber or Ri	ural Route Nur	mber, City or Town, S	State, Zip Code)	
MD and 2 sho alth and m 27 is		Robert C. Tucke	er, Jr./ So						Road,	Crozier,	Virginia	2303
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 Burial 2 X Cremation	3 Removal from St		Place of Dispos crematory or oth Montgome		:emetery,	1		20c. Location - Git	ty or rown, State	
timent trant:		4 Donation 5 Other Spec			Cremato	rium In	C .	26	, 2016	Bethesd	a, Maryla	nd
Bal permi Depar Impo		21. Signature of Funeral Service Lic	V /	M0033	Re Re	ockvill	e, Inc	ž. 30	o West	Pumphrey Montgomen 0-2805	ry Avenue	Home,
Physician	$\dashv$	23a. Part I. Enter the disease, or con	implications that caused		Do not enter the	he mode of dyir	g, such as	CYTAII	respiratory arr	rest, shock, or heart	Approximate	Interval
Mudical		failure. List only one cause on Immediate Cause (Final disease	each line. a. Atherosclerotic	Cardiov	vascular Dis	ease					Between On: Death	
Examiner		or condition resulting in death)	Due to (or as a conse									
	<u></u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	equence c	νη.							
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O, e be executed ysician and burial - transit	edical	UNPENDED	AMENDED							5-63		
760 ficate l g phys	ŽΙ	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcon	ne of preg			3 Ectopie	ic pregnan		23d. Date of deli Month		- 0.0
Box 6876( death certificate the attending physical for use as the b	siciar	past 12 months?	4 Pregnant at	time of de	nath -	tal death 3 ther (Specify)	/COOp.	c pregnan	icy	WORK	Day Ye	ear
Boy re death the att	ΞL	1 Yes 2 No 9 V Unkno	9 Oliknown									
P.O.	<u>a</u>	Part II. Other significant condition Chronic alcohol abuse	is contributing to death	i but not re	esulting in the u	nderlying cause	given in Pa	art I.	23e. Did to	obacco use contributes 2 No 3	te to the cause of dea	
ords, P.( w requires that sheen signed	eted	16			-				24a. Was		re autopsy findings a	
Recol	Completed								autop perfor 1 <b>V</b> Yes	ormed? deat	r to completion of car th? Yes 2	No
Vital Rec sysician: The l this certificate b	BeC	25. Was case referred to medical examiner?				26.Pla	ce of Death	(Check o			,	
Vit	၉	1 🗸 Yes 2 No	Hospital: 1 Inpatie		ER/Outpatient		Other <sub>4</sub>			Residence 6 🗸 0	Other Scene	
Division of Vital Records, tal or Attending Physician: The law requirers after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should to		27. Manner of Death  1  Natural 5 Pending		ry ear)	28b. Time of Ir	· ·   _ ·	njury at Work	_ I	28d. Describe i	how injury occurred		
ViSiC or Atte frer dea birecto	Certification:	2 Accident Investig	28e Place of In	ijury - At h	I ome, farm, stree	I et, factory, office	a building, e	tc.		Street and Number o	or Rural Route Numb	er, City
Divi spital or . nours after neral Dir filled in I	let.	4 Homicide determin						ļ	or Town, S	itate)		
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	ledical C	Check only	sician: To the best of my		_							
To the within To the comp	Medi	29b. Signature and title of certifier	and manner stated.	Illi idador .	Haror in song		nse number		trie time, da.	29d. Date signed		
	-	4/1/	On				C.M.E.			October 22, 2		
	-	30. Name and address of person wh	no completed cause of d	leath (Item	1 23a)					<u> </u>		
			Assistant Medical	l Examir	ner 111 P	Penn Street,	Baltimor	e, MD 2	21201			
St Regist	_	31. Date filed (Month, Day, Year)	32. Registra	r's Signatu	ure back							

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Particular   Control   C		Examir	ier	Ć 11	1	4b. City, Town, or Location of Deat	h ·	4c. County of Deat	h C-anyco
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Prisician Medical Examiner    Medical Examiner   Medical   Medical		90 E 8 9		Must !	bach	MAM 1939 W	Midvalla	Dr Jesie	(/
Section   Sect				shock, or heart failure. List only one caus	s that caused the death. Do not one on each line.	enter the mode of dying, such as cardiac	or respiratory arrest,		Interval Between
School Sequence of the continuous of the continu		Medical		disease or condition	Oue to (or as a consequence of):	ia			
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PART OF COLORS AND A COLOR OF	7	bed isit	mine	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):				
TEMALE:    35. Was decedent pregnant in the past 12 months?   1   We Birth 2   Feld death 3   Ectopic pregnancy   1   We B	30	execution and ial-trans	Exa	that initiated events c	Due to (or as a consequence of):				
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29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 Certifying Myrse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 Certifying Myrse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifying Myrse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year)  1 Tvan Zama 9200 Basil Court Largo, MD 20774  31. Date filled (Month, Day, Year) 32. Register's Signature	P.O.	that the	y P	Part II. Other significant conditions contributi	ng to death but not resulting in th	ne underlying cause given in Part I.	23e. Did tobacco	o use contribute to	the cause of death?
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Ivan Zama 9200 Basil Court Largo, MD 20774  State 31. Date filed (Month, Day, Year)  32. Register's Signature	Divis	al or Att s after d al Direct ed in by	1 Cert			street, factory, office			ral Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Ivan Zama 9200 Basil Court Largo, MD 20774  State 31. Date filed (Month, Day, Year)  32. Register's Signature	_	e Hospit 24 hour e Funera	Medica	(Check 2 Medical Examiner: On	the basis of examination and/or in	vestigation, in my opinion, death occurred	at the time, date and place	ce, and due to the o	cause(s) and manner stated.
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Ivan Zama 9200 Basil Court Largo, MD 20774  State 31. Date filed (Month, Day, Year)  32. Register's Signature		Vithii To th	_	29b. Signature and title of certific		29c. License number	29d. D	Date signed (Month	n, Day, Year)
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		Stat Registra			32. Registr r's Signy ture	/			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month / D 5:25 Valentine Louise 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Sandtown Future Care If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Months 1 ☐ M 2 🖺 F Yrs. 92 11 SC 0.3215-16-7769 10d. Inside City Limits 10c City Town or Location 10a. State 10b. County 1 Yes 2 □ No Baltimore NA MD 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21217 1809 Presstman Street 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Private Domestic 3rd Grade na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marie James Orange James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Livonia, MI 48152 29627 Nottingham Circle, Johnson-Daughter Mary Johns 20a. Met lod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Park 10/27/2010 Woodlawn, Md Donation 5 Other (Specify) 21. Sign Jure of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Pint1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Inmediate Cause (Final disease or condition resulting in death) thrive Failure To Due to (or as a consequence of). Hypertownion Due to (or as a consequence of) de Advance Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

**Funeral** 

Director

or 28a-f show

itema 23a

9

"netural",

al Hygiene.

t of Health and Mental Hyg if Item 27 ie marked other or other traumatic event,

permit. Page Depertment o important: if any injury or once.

the Madical Examiner must be notified at

Funeral Director

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Be Completed

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with the Maryland

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed use as the burial-transit P.O. Box 68760 ò ed by the a Division of Vital Records, been signe should be o or Attending Physician: ě this After the funeral

death.

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in by

hours after death uneral Director:

within 24 hours a

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner IF FEMALE 23b. Was decedent pregnant 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 1 🗌 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient Other: 4 🖾 Nursing Home 5 🗀 Residence 6 🗀 Other (Specify) ٩ 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death Certification: 1 🗖 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Medical

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10-26-2010 M.D 00065383

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

292010

5415 old Court Rd Swit #101 Randallstown M1) 21133 HOUDHRY SHABBIR A 32. Registrar's Signature 31. Date filed (Month, Day, Year)

24b. Were autopsy findings available prior to completion of cause of death?

1 🗆 Yes

2 🗆 No

State Registrar

DHMH 17 Rev 1/2001

Weddle Francis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  State of Maryland / Department of Health and Mental Hygiene												
		_	For State Registrar	State of M	arylan	•	ertificate of		Mental Hy	/GIEN Reg. N	2010	34050
	ysicia Medic		Decedent's Name (First, Middle     Francis Henry	Last) Weddle					2. Date of Do Month	eath 2	ay 20/C	3. Time of Death
,	kamin	u.	4a. Facility Name (if not institution,	give street and number)	- 1	1		or Location of Dea	ith	4	c. County of Deat	า
	neral ector		5. Social Security Number 218–26–2808	9446 1405 6. Sex 1 12 M 2 □ F		ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		10 1929	g, Birl	nplace (State or Foreign Intry) Tand
and	at	o.	Usual Residence of Decedent  10a. State 10b. County			y, Town or L						10d. Inside City Limits
ie Maryk	notified	Director	Maryland Baltin	more	1	Middle	River			10a C	Citizen of What Co	1 Yes 2 X No
with the	nust be	= 1	201 Larkspur Lai	ne			21220	)			J.S.A.	
nd 21215-0036 filed within 72 hours after death with the Maryland all Hygiene all Hygiene 93a or 98a-f sho	amy follows of the traumatic event, the Medical Examiner must be notified at once.	至	11. Marital Status  1 ☐ Never Married 2 ☐ Marr  3 □ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces?  ied Yes, Give Year or Dates.		rea 13.	Was Decedent of If Yes, specify Cub  1 ☐ Yes 2 ☒☒ 1		Specify Yes or <b>No</b> rto Rican, etc.)	-	14. Race - Ame Black, White Specify:	
21215-0036 within 72 hours after gjene.	edical	Completed		t's Education st grade completed)		(Give	edent's Usual Occu kind of work done	during most of w	orking	16b.	Kind of Business	industry
within giene.	the M		Elementary/Seconday (0-12)	College (1-4 or 5	5+)		oo NOT use retired			Law	Enforce	ement
land the filed fental Hy	tic event		17. Father's Name (First, Middle, L Henry Thomas We	,					ame <i>(First, Middle</i> Adele Sc		,	
Baltimore, Maryland permit. Page 1 and 2 should be filed Department of Health and Mental Hy moortant: If them 27 is marked by	r trauma		19a. Informant's Name/Relationsh Michele Jecelin				ing Address (Street Elmhurs					
imore, M Page 1 and 2 s ment of Health	or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation		C	emetery, cre	osition (Name of ematory or other pla		Date	1	Location - City or	
Baltimo permit. Page Department of	any injun	1	4 ☐ Donation 5 ☐ Other (S 21. Signature of Funeral Serviced		HOT.		1 Mem. Ga 22. Name and Addre Bi					Maryland
		4	23a. Part 1 Pinter the disease, or shoot, or heart failure. List o	complications that caused	d the deatl		<u> 1407 Ola</u>	<u> Fastern</u>	Avenue,	_ESS	ex, Mary	Approximate Interval Between Onset and Death
Physic Med Exan	dical		distase or condition sulting in death)	a. Kes p Due to (o as	a consequ	toruence of):	y fail	use				
LAGII	mier	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. USua	a consequ	ntek Jence Oij.	stita	Pno	eumo	nic	a	
executed an and	urial-transit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	c. Diffu	Se a consequ	A/V	eo/ar	Dis	ease			
760 cate be	the bur	edica		La Preu	mo	onia						
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici	shed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1  Live Birth 4  Pregnant a 9  Unknown	2 Feta	al death 3	☐ Ectopic pregnar ☐ Other (specify) _	ncy			23d. Date of del Month	ivery Day Year
S, P.O.	d be detad	è	Part II. Other significant condition	ns contributing to death b	ut not res	ulting in the	underlying cause g	iven in Part I.				the cause of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death.  il Director: After this certificate has been signed by t	age 2 shoul	Completed							24a. Was auto perl 1 \sum Yes	psy	prior to	copsy findings available completion of cause of
ital Fician: Tician: T	ector, p	a l	25. Was case referred to medical examiner?	Hospital:			Ott	Place of Death (Cr		2 (2.51	101	2 - 110
on of Violenting Physical Line.	funeral din	cate: To	1 ☐ Yes 2 🗖 No  27. Manner of Death  1 💆 Natural 5 ☐ Pendin 2 ☐ Accident Investic	1 X Inpati 28a. Date of inju (Month, Da	ry	28b. Time of injury	of 28c. Inju	4 LJ Nursing ry at	Home 5 Res		6 Other (Spec ary occurred	ify)
ivisio I or Atter after dea Director	d in by the	Certificate:	3 Suicide 6 Could determ	not be	ury - At ho c. (Specify	ome, farm, st	reet, factory, office	-7/2	28f. Location City or To	(Street a. wn, Stat	nd Number or Ru e)	ral Route Number,
Hospita 24 hours	eted fillec	Medical	(Check 2 Medical E	Physician: To the best of xaminer: On the basis of e Nurse Practioner: To the	xamination	n and/or inve	stigation, in my opin	ion, death occurre	d at the time, date	and plac	e, and due to the	cause(s) and manner stated
To the vithin	сошо		29b. Signature and title of certifier				29c. Licens	se number		29d. D	ate signed (Month	, Day, Year)
	İ		30. Name and address of person v	yho completed course of d	eath (Item	23a) (Time	Res	0000		10	-28 - 2	70/0
			Dr John R	omano (	7000	Fra	Arlin S	quale	Drive F	Bal.	Limore	2010 , MD 21237
Re	Stat gistra	e ir	31. Date filed (Month, Day, Year)  OCT 2 9 2010	32. Registr	's Sign	and	•					

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM#5perff, G909, 11,3/2010, WS

Certificate of Death

Reg. N. 2010 For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 1:30 PMM 10 2010 Theresa Laura Wright Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Stella Maris Hospice Timonium 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🗶 F Months Days Hours Min. 03/15/1919 Maryland Director 91 Usual Residence of Deceden 3a or 28a-f show t be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State death with the Maryland Director 1 🗌 Yes 2 🔀 No Baltimore Baltimore MD 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral U.S.A. must | 21236 9507 Perry Brook Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Examiner Armed Force Rlack. White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. "natural", or by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: Completed 3 XWidowed 4 Divorced Department of Health and Mental Hygiene.
Important: If frem 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Order Filler Cannon Shoe Company Be iled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert Parks Mary Schmehling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21236 9507 Perry Brook Court - Baltimore, Maryland <u>James S. Wright, Jr.</u> (son) CTOBER 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date cemetery, crematory or other place) 1X Burial 2 Cremation 3 Removal from State Park Cemetery 10/29/2010 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. CE. 11750 Belair Road - Kingsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) CONGESTIVE HEART FAILURE Medical Due to (or as a consequence of Examiner Sequentially list conditions, Examiner if any, leading to immediate
Cause (Disease or iinjury Due to (or as a consequence of): as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 X No õ Month Day Year Pregnant at time of death should be detached 9 Unknown been signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? THERESA WRIGHT 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy death? this certificate 2 🗌 No Yes 2 X N funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🗌 Yes 2 X No 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE မှ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 24 hours after death.

Funeral Director: After work? iniury 1 X Natural 5 Pending Accident Investigation the 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title 20 ess of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 292010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death October 2d, Physician/ 2010 7:40 A. Deborah Rose Wade Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore City 3622 Hineline Road 9. Birthplace (State or Foreign Country) Balt, Maryland 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, April 24 Months Min 1 □ M 2 🕱 F 24 213-27-6469 Director Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Maryland N/A Baltimore 1 XX/es 2 No De filed within (2 1100).

ental Hygiene.

rrked other than "natural", or items 23a or 28

-1.0 avent, the Medical Examiner must be no. 10g. Citizen of What Country's United States 10f. Zip Code 10e. Street and Number Funeral 3622 Hineline Road 21229 America Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc 1 Yes 24
If Yes, Give
Year or Dates. 1X Never Married 2 ☐ Married ģ 2XXNo Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 X No Specify. 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Greeter Retail Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 1 and 2 should be filed of Health and Mental Health and Mental Health and Mental Health 2 Phyllis Elizabeth Blinco Raymond Lee Wade 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3622 Hineline Road Baltimore, Maryland 21229 Mr. Raymond Lee Wade/ father other 1 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition October Department of H Important: If ite any injury or ot Evans Funeral Chapel – Bel Air 1 Burial ACT Cremation 3 Removal from State Forest Hill, Maryland 4 Donation 5 Other (Specify) 26, 2010 21. Signature of Fundal Service Ligense 22. Name and Address of Facility
Peaceful Alternatives Funeral and Cremation Center, PA 2325 York Road Timonium, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line iterval Between Onset and Death Immediate Cause (Final Physician/ **Sepsis** disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) signed by the at d be detached fo 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 2 No 3 Probably 4 Unknown 1 Tes Completed page 2 should peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perforn 1 Yes 2 No certificate or Attending Physician: funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 1 Inpatient 2 ER/Outpatient 3 DOA မ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify, After this 28a. Date of injury (Month, Day, Year) 28b. Time of Manner of Death 28d. Describe how injury occurred 28c. Injury at Certificate: injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending s after death. Investigation Accident the f 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide determined within 24 hours a

To the Funeral D Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 10/26/2010 Res-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 601 N. Carolinest, 7th Floor, Baltimore, MD 21287 RUPA KRISHNASWAM 31. Date filed (Month, Day, Year 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

2 9 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 24 **Physician** Augusta Elizabeth Wolff 2010 October 10:52p /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Carrol1 Sykesville Transitions If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 4 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1921 1 ☐ M 2 ☐ (F 89 218-09-1729 May MD Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10b County 10c. City, Town or Location show rai", or items 23a or 28a-f show Examiner must be molified at Carroll Sykesville MD 1 □ Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene. USA 21784 Apt. 200 7426 Village Rd. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: white Saltimore, Maryland 21215-0036 1 □Yes 2 No Specify Completed by 3 X Widowed 4 □ Divorced 'natural", 16b. Kind of Business/Industry event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) domestic homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 Is marked of traumatic even Rose Grasio Dominic Pilli ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6526 Shenandoah Dr., Sykesville, MD 21784 19a. Informant's Name/Relationship (Type. Print) Mary L. Miner (daughter) Health em 27 l other Important: If item 2 any injury or other once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Loudon Park Cemetery | 10-27-10 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Fune al Service Licensee P.O. Box 195, Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician netostalue /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and strans Due to (or as a consequence of): Box 68760, Physician/Medical attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) signed by the a Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 DNO 2 🗆 No 1 □ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗆 Mo 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred spital or Attending P nours after death. neral Director: After t y filled in by the funera After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00050763 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERNESTO MENDOZA M.D. - 7309 SECOND AVE, SYKESVILLE, MD 21784

le

State Registrar

31. Date filed (Month, Day, Year, OCT 29 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Carmella Marie Wischhusen T 12 2010 Dm /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Harford HEalth and tation 8. Date of Birth (Month, Day, Sept 14, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours New York 1 □ M 2 🖾 F 74 219-32-7511 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No MD Harford Edgewood Director 10g. Citizen of What Country? USA 10e. Street and Number 2009 Hanson Road 21040 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. within 72 hours after 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married white Baltimore, Maryland 21215-0036 1 ☐Yes 2 🔀 No Specify. ⋛ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry unk 16a. Decedent's Usual Occupation un 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) unk College (1-4or 5+) unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be fill the and Mental H Be Nellie Bayne Louis Trotta ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 and 2 s Health a 10114 Fontain Dr; Parkville, Department of Health Important: If item 27 any Injury or other tr Henry Laumann Jr - nephew 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board 21. Signature of Funeral Service Paon all d irector 655 W. Baltimore Street; Baltimore, MD 21201 Approximate Interval Between Onset and Death 23a. Par 1. Enter the disease, it complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shirts or heart failure. List only one cause on each its Immediate Cause (Final disease or condition resulting in death) Treas **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 9 Unknow cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 1 ☐ Yes 2 ☐ No 2[ 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one Be examiner? Other: 4 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After t Natural 5 Pending investigation To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur 1 ☐ Yes 2 ☐ No Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Extifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 Medical Examiner (Check only one) and manne 29b. Signature and tit of cer death (Item 23a) (Type, Print 30. Name and address of person who completed cause ſ Registrar's Signature 31. Date filed (M State Registrar

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health and Mental Hygiene  1 - State Registrar  Certificate of Death  Reg. No. 0   0	34055
	Physic		1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day Year	3. Time of Death
	/Medi Exami		4a. Facility Name (If not institution, give street and number)  Mercy Medical Center  4b. City, Town, or Location of Death  Baltimore	1015
	Funeral Director		5. Social Security Number 214-26-0913 6. Sex 1 7. Age (In yrs. last birthday) 1 9. Birthp Count Months Days Hours Min. (Month, Day, Year) 4 9. Birthp Count Mary.	olace (State or Foreign htry) 1 and
8	Aaryland f show	ō	Usual Residence of Decedent  10a. State	0d. Inside City Limits 11X Yes 2 □ No
	3a or 28a-	al Director	10e. Street and Number 206 Silver Court  10f. Zip Code 21213  USA	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its M. dical Examinations to not be conce.	by Funeral	3 ☐ Wildowed 4 ☐ Divorced Year or Dates:  1 ☐ Yes 2 ☒ No Specify: Specify: Specify:	etc.
Maryland 21215-0036	d within 72 ho giene. er than "natur ir. N. cical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  8  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  cook  restaurant	,
yland	ould be file Mental Hy arked othe atic event,	To Be (	17. Father's Name (First, Middle, Last)  Snowdy Wallace  18. Mother's Name (First, Middle, Maiden Surname)  Bessie Johnson	
	1 and 2 sho Health and Im 27 is m		19a. Informant's Name/Relationship (Type. Print)  Shirley Hollvin - sister  29 Bunche Street; Annapolis, Maryland 2	21401
Baltimore,	it. Pages introduced the relation of the relat		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 ☑ Other (Specify) In State	wn, State
Ba	permi Depar Impor any ir		21. Signature Funeral Street Licens and Address of Facility State Anatomy Board 655 W. Baltimore Street; Baltimore,	
	Physician /Medical Examiner			Approximate Interval Between Onset and Death
<u>,</u>	ficate be executed physician and sthe burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Urseas or infury that initiated events resulting in death) Last  Due to (or as a consequence of):  c	
68760,	tificate be ig physicia as the bur	dical	d	
P.O. Box	at the death certifi by the attending tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?   23c. If yes, outcome of pregnancy   1 □ Yes 2 □ No   9 □ Unknown   23d. Date of deliver   Month   1 □ Yes 2 □ No   9 □ Unknown   1 □ Inknown   23d. Date of deliver   Month   1 □ Yes 2 □ No   9 □ Unknown   1 □ Inknown   23d. Date of deliver   Month   1 □ Yes 2 □ No   9 □ Unknown   1 □ Yes 2 □ No   9 □ Unknown   1 □ Yes 2 □ No   9 □ Unknown   1 □ Yes 2 □ No   9 □ Unknown   1 □ Yes 2 □ No   9 □ Unknown   1 □ Yes 2 □ No   9 □ Unknown   1 □ Yes 2 □ No   9 □ Unknown   9 □ Unknown   1 □ Yes 2 □ No   9 □ Unknown   1 □ Yes 2 □ No   9 □ Unknown   9 □ Unkno	ry Day Year
Records, F	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the	
Vital Rec	sician; The law I certificate has b irector, page 2 sh	e Completed	autopsy prior to comperformed? death?  1 Yes 2 No 1 Yes 2	osy findings available inpletion of cause of
Division of Vi	Phy ald	Certification: To Bo	examiner?    Sexaminer   Check only only	)
N N	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funeral Director.		4 Homicide determined 28e. Place of Injury - At nome, farm, street, factory, office 28f. Location (Street and Number or Rural City or Town, State)  29a. Certifier 182 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state.	atod
	To the Ho within 24 I To the Ful completely	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, D	the cause(s)
			Thou Ran, mi) D57088 OCTOBER US  30. Name and address of person who completed cause of geath (Item 23a) (Type, Print),	,2010
	Stat Registra	е	31. Date filed (Month, Day, Year)  OCT 29 2010  32. Registrar's Signature  OCT 29 2010	
	riegistia	"	OUT NO FOLD OF THE PARTY OF THE	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year Physician/ 5:26 A M Geraldine Loretta Adams October 15 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Prince George's Hospital Center Cheverl 9. Birthplace (State or Foreign Country) Wash. DC 5. Social Security Numbe If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age *(In yr*s. **7**5 **Funeral** 1 - M 2 X F Director 46 2850 1935 7 Fah Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shor Examiner must be notified at Director MD Prince George' Landover 1 Yes 2 No 10e Street and Numbe 10f Zin Code 10g. Citizen of What Country? Funeral USA 1000 Brightseat Rd. 20785 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼No If Yes, Give 11. Marital Status Black, White, etc. Specify: Black þ 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 ☐ No Specify: "natural", 3 ₩ Widowed 4 □ Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) Community Aid DC Public Schools 10th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland ပ Ellen Anderson George Trice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 LaMarr A.Adams/ Daughter 2902 Brightseat Rd.Apt.302 Lanham,MD 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If it
any injury or ol Burial 2 Cremation 3 Removal from State 10 26 2010 Bladenburg, MD 4 ☐ Donation 5 ☐ Other (Specify) .Lincoln Cem. 22. Name and Address of Facility Briscoe-Tonic Funeral Home 21. Signature of Funeral Service Lioenses 2294 Old Washington Rd.Waldorf,MD 20601 23a. Part 1. Enter the dijease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear barder. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Fata disease or condition Medical resulting in death) Due to (or as a consequence of) 5413 **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) anding physician and use as the burial-transit that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Dav ō Month Year Pregnant at time of death signed by the a d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò malianent neoplasm 2/ONO Division of Vital Records, 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autonsy death? 2 🗌 No 1 🗌 Yes Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Was case referred to medical 26. Place of Death (Check only one) Be 2 XNO Other: 1 \( \text{Yes} 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ည 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 263 10 5 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marta Anne Schneider, M.D 5401 MacArhur BLVd. NW Washington, DC 31. Date filed (Month, Day, Year) State OCT Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ John Earl Branyan October 11 2010 3:33 PM Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Calvert St. Leonard 5364 Forest Tr. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 5. Social Security Numbe 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 😾 M 2 🗆 F Months 11/27/1949 New Jersev 153-44-9858 60 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 X No St. Leonard Maryland 1 4 1 Calvert 10a. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 20685 United States 5364 Forest Tr. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 12. Was Decedent Ever in U.S. 11 Marital Status d Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 X Yes 2 If Yes, Give Year or Dates. þ 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: "natural", 3XX Widowed 4 □ Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event, the Medic (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Energy Engineer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 0 Jessie Stone Brewer Harry Emerson Branyan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 45556 Grand Centeral Square, Sterling, Virginia Eric Galen Branyan / Son 20a. Method of Disposition
1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 10/16/2010 Port Republic, Maryland Chesapeake Highland 4 Donation 5 Other (Specify) Rausch Funeral Home, PA. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4405 Broomes Island Road, Port Republic, Maryland 20676 Kyle S. Simons MO1206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician METASTATIC ANCRETS disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Litter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed plnous peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy this certificate has death? Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Director: After injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number determined within 24 hours after To the Funeral Direct 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0066507 200. 12 annyA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Magny la ST PANDY MAIMISH 31. Date filed (Month, Day, 32. Registrar Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month ber Paul Edward BECKLEY 7:20AM 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye Sept 23, g. Birthplace (State or Foreign 62 220-54-2788 1948 Maryland Sept. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Washington 1 🗌 Yes 2 🔀 No Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Apt. 9E, Hopewell Road 21795 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) welder stair fabricator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Walter Perry Beckley, Sr. Mary Pearl Harsh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn K. Beckley - wife 9E, Hopewell Road, Williamsport, Md. 21795 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Salem Reformed Ch.Cemi 10/22/10 Hagerstown, Maryland 21. Signature of Funeral Service Licenses Meme and Address of Facility MINNICH FUNERAL HOME Wilson Blvd., Hagerstown, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. enter the mode of dying, such as cardiac or respiratory arrest, Interval Between DNEUMON.A ASPIRATION Onset and Death disease or condition

To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760 within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu

Physician/

Medical

Director

Funeral

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Completed

Be

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**Examiner** 

**Funeral** 

Director

items 23a or 28a-f show

"natural", or items 23a or 28a-f sho edical Examiner must be notified at

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at

Physician/

Medical Examiner

Baltimore, Maryland 21215-0036

9H-4

resulting in death)										
_		Due to (or as a consequence of):  RECURRENT RESPIRATORY PAILURE  Sequentially list conditions,								
Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to (or as a consequ	-VEBER	-READU S	TNDROM	ť				
edical E	resulting in death) Last	Due to (or as a consequence of):  d. LIVER (IRRHOS)S								
9										
nysician/n	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ic. If yes, outcome of pregna  1  Live Birth 2  Feta  4  Pregnant at time of c	ic pregnancy (specify)		23d. Date of de Month	elivery Day Year				
-	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to									
3										
200										
	25. Was case referred to medical examiner?			26. Place of Death (Che	ck only one)					
2	I L Yes 2 2 No		ER/Outpatient 3	DOA Other: 4 Nursing H	lome 5 ☐ Residence	6 ☐ Other (Spec	cify)			
- Cate	27. Manner of Death  1	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No	ury occurred					
	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify,	me, farm, street, fact	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  3 Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier			9c. License number		ate signed (Mont				
	MOHLMMED	AZIZ		D66892	) (	0/19/1	C			

251 Antietam St., Hagerstown, Md. 21740

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Dr. Mohammed S. Aziz,

OCT

31. Date filed (Month, Day, Year

State

Registrar

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Glorine E. Buckner 20<sup>rear</sup>0  $P^M$ October 1:18 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Agnes Health Care Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🏝 F Months Davs Hours (Month, Day, Year) Dec. 8, 1946 Director 224 60 9029 63 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD Anne Arundel Lothian 1 X Yes 2 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 6 Patuxent Mobile Estates 20711 or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give filed within 72 hours after Maryland 21215-0036 1 Yes 2 No Specify. Specify:Black "natural" 3 Widowed 4X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any injury or other traumatic event, the Mea my injury or other traumatic event, the Mea College (1-4 or 5+) /Seconday (0-12) Labor Union Steward Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard Buckner Mary Stepney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13161 Haybrown Ct.Woodbridge, VA 22192 Sandra Conway/Daughter 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State ochBaptist<sup>Cem</sup>. 10/19/10 King George, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Cedell Brooks Funeral Home 25662 A.P. Hill Blvd.Port Royal, VA 22535 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HOUTE MYDOARDIAL INFARCTION Pnysician/ disease or condition resulting in death) Minutes Medical Due to (or as a consequence of) Examiner DISENSE CORONARY Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed physician and the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown signed by the a 9 Unknown Division of Vital Records, P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ ACCIDENT CEREROVASCULAR ONE 1 ☐ Yes 2 ☐ No 3 💆 Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No PRIOR DEATH 24a. Was an certificate has autopsy performed? Yes 2 N To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 2 Accident
3 Suicide
4 Homicide 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

Medical

31. Date filed (Month, Day, Year)

29a. Certifier

(Check

29b. Signature and title of certifier

MIS 32. Registrar's Signatur

Durkumoh

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

18

St. Agnes Hospital

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D46505

29d. Date signed (Month, Day, Year)

DCTOBER 14,2010

900 Caton Avenue Baltinire

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month RONALD HERMAN **BROWN** 11:10AM 2010 October Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Center Towson Baltimore Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 D F Hours MAR 13, 1935 220-30-6134 Director BALTIMORE, MD Usual Residence of Decedent 28a-f shov 10a. State 10b. Count with the Maryland 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director DELAWARE SUSSEX COUNTY SELBYVILLE 1 Yes 2 No ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 37112 HUDSON ROAD UNITED STATES death 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or ģ 1 Never Married 2 X Mamied permit, Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinancine. Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Completed 3 Widowed 4 Divorced Specify: WHITE Year or Dates.1953-57 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) AUTO ASSEMBLY MAINTENANCE TECHNICIAN PLANT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည PETER HERMAN BROWN ELIZABETH SCHECKELLS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 37112 HUDSON ROAD; SELBYVILLE, DE 19975 HELGA TITCHER BROWN (WIFE) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State OCT 19,2010 MILLSBORO, DE FIRST STATE CREM. CTR. 4 ☐ Donation 5 ☐ Other (Specify) Service ⊌icensee 22. Name and Address of Facility MO 1361 WATSON FUNERAL HOME PO BOX 125 MILLSBORO, DE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Priysician/ pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner anaplastic Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) g physician and as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day signed by the a Yes 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾| Nuocard 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical the funeral director 26. Place of Death (Check only one) Hospita 2 No Other: 1 Tes 잍 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work?
1 Yes 2 No Investigation Accident Director 3 Suicide 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year)

State Registrar harles

32. Registrar's S

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

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			for State Registrar	Oldio or ivi	ai yiai ii	-	rtificate of		i workar rij	Reg. N	2 H I H	34062
			Decedent's Name (First, Middle, Language)	a <i>st)</i>					2. Date of D	eath		3. Time of Death
	Physici /Medio		Lillian Sara Bi	shop					Month		0 2010	2016 M
	Examin		4a. Facility Name (If not institution, gi				4b. City, Town, o	r Location of Dea		4	c. County of Deat	
ng t			Memorial Hospi				Eastor				Talbot	
	Funeral Director			Sex 7.Ag 1 □ M 2 🛣 F	je (In yrs. la 83	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hi Hours Min		rth <i>ay, Ye</i> a <b>10</b> 27	9. Birt Co 7 Min	hplace (State or Foreign untry) Lrvland
			Usual Residence of Decedent		0.5				02/22/	1741	, Nic	iryrand
	ırylan show	_	10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
	8a-f	Director	MD Carolin	e	Gree	nsbor						1 □Yes 2 🛣 No
	a or 2	ä	10e. Street and Number				10f. Zip Code				Citizen of What Co	
	ns 23	Funeral	12643 Porter's L	12. Was Decedent	Ever in U.S	S. 13.	21639 Was Decedent of H		(Specify Yes or N		Ited Stat	
٥	or iter	Fu	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🔼		1	Was Decedent of H		erto Rican, etc.)		Black, White	
51215-0036	be filed within 72 hours after death with the Maryland ital Hyglene. d other than "natural", or items 23a or 28a-f show event, the Madeal Entiring out by natified at	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 □Yes 2M∏No	Specify:			Specify: Whi	te
<u>.</u>	"natu	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retire	oation during most of w	orking	16b.	Kind of Business/	Industry
7	filed within 72 Hygiene. other than "na ent, The Medic	шc	Elementary/Secondary (0-12)	College (1-4or 5	5+)		ce Presid			1	Banking	
	filed Hygi other ent,	Be Co	17. Father's Name (First, Middle, Las	t)		ΑΤ(	e ilesid		ame (First, Middle			
<u>la</u>		To B	Frank B. Breedi	ng				Sarah 1	Pearson :	Bree	eding	
Maryland	d 2 should th and Mer 7 is marke traumatic		19a. Informant's Name/Relationship	(Type. Print)		19b. Mailir	ng Address (Street					Zip Code)
	es 1 and 2 of Health fitem 27 r other tr		Maurice Porter/n	ephew								, MD 21639
o E	ges 1 it of H # itel or otl		20a. Method of Disposition 1 Durial 2 □ Cremation 3 D	☐Removal from State	20b. Pi	ace of Dispo emetery, crer	sition (Name of natory or other plac	ce)	Date	20c.	Location - City or	Town, State
baltimore,	it. Pa rtmer rtant: njury		4 □ Donation 5 □ Other (Special	ify)	Gre		o Cemete		14/10	Gre	ensboro,	MD
g	permit. Pages 1 Department of H Important: If ite any injury or ot once.		21. Signature of Funeral Service Lice	nsee			2. Name and Addre		106 1		MD 21639	0 1
	_		23a. Part 1. Enter the disease, or con	nplications that caused	the death						inset Ave	Greensboro Approximate Interval Between
,	Physician		shock, or heart failure. List only Immediate Cause (Final	one cause on each lir	ne.				~			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as	a consequ	ence of):	yocard	11011	NEAL	Ch	-00	
	Examiner		Sequentially list conditions	b								
	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequ	ence of):						
•	axecul and al-tran	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequ	ence of):						
09/90	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	ical	· ·	ď	,	,						
0	tificate ig phys as the											
NO P	th cer tendir r use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Ectopic pregnanc	°V			23d. Date of del	•
	ie dea the at ned fo	sici	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown			Other (specify)	,			Month	Day Year
	that the set by detacl		Part II. Other significant conditions	contributing to death b	ut not resul	Iting in the u	nderlying cause giv	en in Part I	23e. Did	tobacco	use contribute to	the cause of death?
cords,	ures sign ld be	d b	•	g			,, g				/	obabły 4 ☐ Unknown
5	w req	Completed							24a. Was	an	24b. Were au	topsy findings available
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	ding Physician: The law requires that the death certifics h.  After this certificate has been signed by the attending ph funeral director, page 2 should be detached for use as the content of the conten	BeC	25. Was case referred to medical examiner?			-		26. Place of De	1 ☐ Yes eath (Check only	2 🛂 one)	No 1 ⊔Yes	2 No
5	hysic his ce I direc	2	examiner? 1 □ Yes 2 ☑ No	Hospital: 1 ☐ Inpatie	ent 2 🗆 E	R/Outpatier	t 3 DOA Oth	er: 4 🗆 Nursing	Home 5 ☐ Res	idence	6 ☐ Other (Spec	cify)
ָם סבי	Ing P	ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Day		28b. Time of Injury	Wor	k?	28d. Describe	how inj	ury occurred	
	death death stor: / the i	icat	2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b	e 29a Bloop of Init	uni - At hor	no farm etr	M 1 □ eet, factory, office	Yes 2 □ No	29f Location	Ctract	and Number or Ru	un I Pouto Number
<u>}</u>	after Direction by	Certification:	4 ☐ Homicide determined	building, etc	c. (Specify	)	set, lactory, office		City or To			rai Adule Number,
:	Io the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funeral or the funeral		29a. Certifier 1 CertifyIng P	hysician: To the best	of my knov	vledge, deatl	occurred at the ti	me, date and pla	ce, and due to the	e cause	(s) and manner as	stated.
	in 24 in 24 the Fu	Medical	(Check only 2 Medical Exa	miner: On the basis of and manner sta	t examinati	ion and/or in	vestigation, in my o	opinion, death oc	curred at the time	, date a	and place, and due	to the cause(s)
i	ro the within To the сощр!	Σ	29b. Signature and title of certifier		. (*	ON	29c. Licens	e number			Date signed (Month	n, Day, Year)
										10	111/2	011
			30. Name and address of person who				Print)		2	7 <	w who	10 21655
	Stat		31. Date filed (Month, Day, Year)		ar's Signat		Turk +	3000	we ,	-	1 900 1 4	.,, ,,,,,

Registrar

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene

State of Maryland / Department of Health and Mental Hygiene

23a,27,28a-i per me,g926,04/16/2012dnb

Certificate of Death

Reg. No. 2 | | 1, Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year Leon Eugene Barrett 14.57 PM October 08 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** AGINES BALTIMORE HOSPITA If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs, last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months 1 X M 2 - F Sept. II, 1966 215-94-4329 44 Yrs. MD **Director** Usual Residence of Decedent show 10b. County 10a. State 10c, City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD 28a-f Baltimore Baltimore 1 ¥ Yes 2 □ No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code items 23a Funeral 22 South Athol Avenue 21229 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Black, White, etc. "natural", or 2 1 Never Married 2 Married ☐XYes 2 ☐ No Yes, Give Baltimore, Maryland 21215-0036 **Black** 1 ☐ Yes 2 🕅 No Specify: Specify: Completed 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical any injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Carpet Installer Carpet 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Sample Charlotte Barrett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen M. Barrett/Sister 124 N.: Conwell St., Seaford, DE 19973 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State Eastern Sh. Veterans Cem 10/18/10 Hurlock, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, 216 NJ Main St., Federalsburg, MD 21632 21. Signature of Funeral Service Licensee Christine Zakow M. 23a, Part 1. Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ PNEMONIA disease or condition resulting in death) days Medical Due to (or as a consequence of): Examiner Head Injuries with Complications Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) APPROVED BY MEDICAL EXAMINER Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): CERTIFICATION Physician/Medical BARRETT LEON Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗌 Yes 2 🖳 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Other: \_4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဂ္ 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28d Describe how injury occurred
Subject bicyclist collided 1 Natural
2 X Accident 10/2006 injury Unknown M Unknown 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Investigation 6 Could not be with truck. ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State West Bound East Central Unknown Ave. Federalsburg, MD. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Roadway Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) P 25488 October 12th. 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 S. Caton Avenue Baltimore. 21229. Susmita Sakruti 31. Date filed (Month, Day, Year) Registrar's Signature State OCT 1 3 2010

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Der State Amend Items 23aPtI,25 per me,g	partment of Health and 1 08,10/29/2010 dib, Pertificate of Death	4ental Hy	giene Reg. No. 2010	34064
	DI	,	Decedent's Name (First, Middle, Last)	-	2. Date of Dea	ath	3. Time of Death
	Physicia Medio		Virginia O. Crouch		08-17	7-2010 Year	16:20 PM™
1	Examin	ıer	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			Southern Maryland Hospital	k Clinton		PG	
	Funeral Director			If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birt (Month, Day 01–28	h 9. Birthpla	ace (State or Foreign n Carolina
			Usual Residence of Decedent		1 01-28	5-1920   North	n carolina
	shov dat	호	10a. State 10b. County 10c. City, Town or I	ocation		100	d. Inside City Limits
	Mary 28a-f ptifie	Director	MD PG CI	inton			1  Yes 2 □ No
	a or	<u>=</u>	10e. Street and Number	10f. Zip Code		10g. Citizen of What Country	y?
	h witl ns 23 nust	Funeral	8706 Dangerfield Place	20735		US	
	r iten	교	Armed Forces?	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americar Black, White, etc	
39	after al", o xam	d by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Vidowed 4 Divorced Year or Dates	1 ☐ Yes 2 🛣 No Specify:		Specify: Blac	
ğ	within 72 hours after death with the Maryland giene. giene, than "natural", or items 23a or 28a-f sho tthe Medical Examiner must be notified at	Completed	15. Decedent's Education 16a. Dec	edent's Usual Occupation	- 51	16b. Kind of Business Indu	
212	n 72 l an "r Med	를	(Specify only highest grade completed) (Giv	e kind of work done during most of work DO NOT use retired)	ing	TOD. TUILD OF DUSINESS MICH	Suy
7	withii giene ier th		10th	Cook		HEW	
Б	be filed ental Hy ked oth ic event	o Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam	, ,	,	
Maryland 21215-0036	ild be Ment narke natic	욘	William Tyner	N	lancy E.	Flythe	
Jar	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatly and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			ling Address (Street and Number or Rura		•	de)
e)	and 2: Health em 27: ther tr		Renee V. Scott - Granddaughter 8706				
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	To the hospital or Attending Fripsicians. The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Directors After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check 2 ☐ Medical Examiner: On the best of my knowledge, death (check only one) 3 ☐ Certifying Nurse Practioner: To the best of my knowledge	stigation, in my opinion, death occurred at	the time, date ar	nd place, and due to the cause	
3	vithin Fo the	≥	29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Da	
			MALMAN	D-24539	>	08,18,1	0
			30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)			0 (-7)
			Laxm. Bexwa 7700 Old branc	have Suite	10101	inton md	20135
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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month October 12, 2010 **Physician** 9:47 a M Alice M Carter /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Calvert Memorial Hospital Calvert Prince Frederick If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Days Min 1 □ M 2 🗹 578-32-2440 85 December 26, 1924 MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 ☑ No Director Calvert Sunderland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 225 Pushaw Station Road USA 20689 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White, etc. 1 Never Married 2 Married 1 □Yes 2 No Specify. ò Specify: 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Certified Nursing Assistant Medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Morsell Blanche Ray ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Claudette C Brown - daughter 225 Pushaw Station Road, Sunderland, MD 20689 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory October 14, 2010 Alexandria, VA 4 □ Donation 5 □ Other (Specify) Sewell Funeral Home, P.A. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CONGESTIVE disease or condition resulting in death) - DRONARI Equentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Kidner 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No (Sx) 1ahm 2 🗆 No 1 TYes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

or Attending Physician; The law requires that the death certificate be executed and burial-tran P.O. Box 68760. attending physician the the signed by t be detach Division of Vital Records, certificate has director, After this funeral To the Hospital or Autenamy, within 24 hours after death.

To the Funeral Director: After the Funeral Director of the full of

**Funeral** 

Director

d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be muffled at

Health and Mental Hygi em 27 is marked other

**Physician** 

/Medical Examiner

injury or other traumatic

Pages 1 and 2 should be nent of Health and Mental

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Certification: To

JRW

State

Registrar

31. Date filed (Month, Day, Year) OCI

29b. Signature and title of certifier

4 Homicide

(Check only one)

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determined

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Prince Frederick, MOZOLOTE

Name and address of person who completed cause of death (Item 23a) (Type, Print) 110HOSPITAURO uhesh

32. Registra s Signature

enun

10-07774 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Eileen Chitty State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Medical Examiner Eileen Janis Chitty October 9, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Calvert Memorial Hospital Prince Frederick Calvert 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In vrs. last birthday) **Funeral** Days Director 217-85-4314 1 M 2 X F 05/14/1952 58 Usual Residence of Decedent 10c. City, Town or Location Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Memial Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov
injury or other traumatic event, the Medical Examiner must be notified at once. Calvert North Beach Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20714 9113 Dayton Avenue Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married Yes 4 Divorced If Yes, Give Year 1 Yes 2 No specify: ⋧ 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Customer Service 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be Iris Smeed Alfred Riefe ٩ 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) North Beach, MD 20714 Denise Mandley/NOK 9113 Dayton Ave., 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Chesapeake Crem. 10/14/10 Beltsville, MD 4 Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Euneral Service Licenses Raymond-Wood F.H., Dunkirk. MD Box 430 **Physician** 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line /Medical a, Complications of Diabetes Mellitus and Chronic Alcohol Abuse Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as e consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - transit Physician/Medical UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy use as 1 Pregnant at time of death Other (Specify 1 Yes 2 V No 9 Unknown for 9 Unknown n signed by the a d be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed this certificate has been a I director, page 2 should 24a. Was an autopsy performed? director, page 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 🗌 DOA ဥ 1 Yes 28a. Date of Injury (Month, Day, Year 27. Manner of Death 28c. Injury at Work? 1 🗸 Natural Pending 1 Yes 2 No

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10d. Inside City Limits

1 X Yes 2 No

Approximate Interval

Between Onset and

Country)

14. Race - American Indian, Black,

White

HK

White, etc.

Banking

20754

Specify:

Division of Vital Records, P.O. Box 68760, 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ✔ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi Other Nursing Home 5 Residence 6 Other 28d. Describe how injury occurred filled in by the Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be determined 4 Homicide 29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 10, 2010 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month. 32. Registrar's Signature State Registrar **ORIGINAL** DOME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 10/12/2010 ear Alphonse John Caplins 1:10 a<sub>M</sub> Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Calvert 3820 Harrison Lane Huntingtown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Rirth Birthplace (State or Foreign Country) **Funeral** Days Hours 216-14-8427 1 M 2 0270671923 **Director** 87 MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Calvert Huntingtown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3820 Harrison Lane 20639 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces ğ 1 Never Married 2 3 Married 1 ★Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Masonry Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Vincent Caplinskas Veronica Navickas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lillian Caplins/Wife 3820 Harrison Lane, Huntingtown, MD 20639 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 x Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory 10/16/2010 Clinton, MD 22. Name and Address of Facility Lee Funeral Home 8125 Southern Md Blvd., Owings, Signature of Funeral Service Licensee Lisa M. Mounts 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical onsequence of: Squamous Cell Ca of Scalf Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death signed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has t 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA o the Hospital or Attending Physical thin 24 hours after death.
I the Funeral Director; After this of impleted filled in by the funeral direction. 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1. Natural iniury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the pest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20678 5

DHMH 17 Rev 7/2009

State Registrar <u>Jonathan</u> D

31. Date filed (Month, Day, Year)

Lowenthall.

110 Hospital Road.

Suite 110.

Prince Frederick

M.D..

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

Physician Ronald Sugene Clark  Control Part Mindful Class Ready Name of Prox Middle, Last)  Ronald Sugene Clark  Control Part Month				For	State of Maryland / [			-	•		
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The state of the s	ta E	(0 11	0	25. Was case referred to medical		20	6 Place of Dooth		No 1 ☐ Yes	2□ No	
Natural 2   Accident 3   Suicide 4   Homicide   Accident 5   See Place of Injury - At home, farm, street, factory, office   See Place of I				examiner? 🗸	ospital: 1 Inpatient 2 ER/Ou	Othor			e 6 Other (Spe	cify)	
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4 Homicide determined building, etc. (Specify)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)	isio	death ctor: / the f	Icat	3 Suicide 6 Could not be	28a Place of Injury - At home fa			8f Location /Stree	at and Number or P	im I Pouto Number	_
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one) and manner stated.  29b. Signature and title of centier 29c. License number 29d. Date signed (Month, Day, Year)		lospita hours unera		29a. Certifier  (Check only 2 Medical Examin	sician: To the best of my knowledge	e, death occurred at the time,	date and place, a	nd due to the caus	e(s) and manner a	s stated.	_
D = 250. Signatural distriction of the control 250. Date signatural districtio		the P thin 24 the F mplete	Medi	Unity .	and manner stated.						
MA NATIONAL	)	T wil	-	200. Signature and title of certifier	A	250. License no	1172	290.	Jale signed (Mont	O O O	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				30. Name and address of person who co	mpleted cause of death (Item 23a)	(Type, Print)	041-		CLOPOV	40, 4011	7
SH-6 Hind Hamdon, MD; 1130 OPAL CT. Hagerstown, MD 21	5	4-6		HindHamday	n, MD : 1130	OPAL C	T. He	igenst	n, nwo	D 2174	0
State 31. Date filed (Month, Day, Year) 32. Figis/rar's Signature				- 0.0.00	40 6	par	,	J			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 1505 Roland Russell Corkell, Sr. 10 -08 -2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TALBOT MEMORIAL HOSPIAL @ EASTON EASTON 9. Birthplace (State or Foreign Country)
Maryland 8. Date of Birth (Month, Day, Year)
Oct. 29, 1938 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Min. 1 X M 2□ F Months Days Hours 214-42-9652 **Director** Usual Residence of Decedent e filed within 72 hours after death with the Maryland al Hygiene.

other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State ed other than "natural", or items 23a or 28a-f sho event, the Wedical Evanding remost be multified at 1 ☐ Yes 2 X No Director Maryland | Caroline Denton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21629 U.S.A. 27086 Anthony Mill Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No 14. Bace - American Indian. 11. Marital Status 1 ☐ Never Married 2 X Married 21215-0036 1 ∐Yes 2 X No If Yes, Give Year or Dates: Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Small Grain 12 Farmer 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) s 1 and 2 should be fil f Health and Mental H item 27 is marked otl Ada Louise Thomas John Wesley Corkell, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2: Department of Health a Important: If item 27 is any injury or other trau once. 27086 Anthony Mill Road, Denton, Maryland 21629 <u>Joan E. Corkell/spouse</u> 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Oct.14,2010 Denton, Maryland Denton Cemetery 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Moore Funeral Home, P.A. thurs I nous 12 South Second Street, Denton, Maryland 21629 Approximate Interval Between Onset and Death 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Due to for as a consequence of: **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine (or as a consequence of) sician and burial-transit Physician: The law requires that the death certificate be executed Due to (or as a consequence of) physician s the burial Box 68760. Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 ☐ Other (specify) signed by the a o 9 Unknown ď Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown as been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an has autopsy page 1 ☐ Yes 24 No After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 patient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident investigation 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital tiance and physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 9:15 Elsie Minerva Cochran October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington County Williamsport Nursing Home Williamsport Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Hours April 20 1923 MaryTand **Director** 216-14-5219 87 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director Maryland Washington County Boonsboro 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18408 Manor Church Rd. 21713 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 🗓 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give White 3 XWidowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 1 and 2 should be filed with if Health and Mental Hygien item 27 is marked other th 9 Homemaker Personal Residence Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev John Leslie Moats Mary Ellen Lambert Moats 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Calvin M. Mahaney-Personal Rep 8853 Sharpsburg Pike Fairplay, MD 21733 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Manor Church Cemetery 10-21-2010 Boonsboro, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph\_sician/ ance? disease or condition resulting in death) ung two years Medical Due to (or as a ton, equence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) Day Year signed by the a 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 3 Probably 4 ☐ Unknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an After this certificate has funeral director, page 2 performed 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be No No Hospital: Other: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 1 Natural work? in 24 hours area control Africant Africant Africant In by the fu Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 3 🗆 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Haccontown MD

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 34071 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 2010 0118 Owen Lynch Dixon Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Easton Memorial Hospital Talbot Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Months Days Hours Min. (Month, Day, Year) 04/16/1931 Maryland Director 79 220-26-7765 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be access 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Caroline 1 Yes 2X No Greensboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 12693 Ridgely Road, Greensboro <u>United States</u> Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) OwnerOf Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Armine Clair Dixon Helen Lynch Dixon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eva Ashton Thawley Dixon/ wife 12693 Ridgely Road, Greensboro, MD 21639 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 0/23/2010 Greensboro, MD Fleegle & Helfenbein Funeral Home Holy Cross Cemetery 10/23/2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility uil 106 W. Sunset Ave. Greensboro, MD 21639 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ ATHEROSCLEROTIC CITADIOVASCULAR DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner OBSTRUCTIVE PULMONARY DISEASE CHRONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) and -transit Hospital or Attending Physician: The law requires that the death certificate be executed CARDIOMYOPATHY that initiated events Due to (or as a consequence of) resulting in death) Last physician a s the bunal-1 Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year 2 No s been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗹 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 🗹 No Other: ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 1 Natural 5 Pending 1 Yes 2 No nours after death neral Director; A ifilled in by the fi Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

DHMH 17 Rev 7/2009

State

Registra

only one)

29b. Signature and title of certifier

John Botsis,

OCT 26

31. Date filed (Month, Day, Year)

olus Potses

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signatu

3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

00059487

219 S. Washington Street, Easton, Maryland 21601

29d. Date signed (Month, Day, Year)

10-19-2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First Middle Last) 2 Date of Death Physician/ Month Year ΡМ October 2010 <u>Lena Josephine Dlugosz</u> Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City Town, or Location of Death 4c. County of Death Loyalton Of Hagerstown Hagerstown Washington County Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Country)
Italy 1 □ M 2 🗓 F Hours Min. 140-14-1034 Director June 87 Usual Residence of Decedent or 28a-f show of Mental Hygiene. marked other than "natural", or items 23a or 28a-f shov imatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland | Washington County 1 Yes 2 No Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13718 Royal Rd. 21742 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 11. Marital Status 14. Race - American Indian, Black, White, etc. 2 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed 3 ₩ Widowed 4 □ Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Health Department 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H Attilio Miranda Rose Perone Miranda 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 40 ge 1 and 2 sh it of Health a Vicky A. Snyder-daughter 906 Pontiac Ave. Frederick, MD 21701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Resurrection Cemetery 10-22-2010 Piscataway, NJ permit. Page 1 and Department of H Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee Eastern Blvd. North Hagerstown 23a. Part 1. Enter the disease, or confications that valued the death. Do not enter the mod shock, or heart failure. List only one cause on path line. Approximate Interval Between Onsettand Death of dying, such as cardiac or respiratory arrest, kin Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) bunal-transit that initiated events resulting in death) Last Due to (or as a consequence of): ending physician a use as the bunal-Physician/Medical Box 68760 use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for u 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death ed by the a detached f P.O. Part II. Other significant conditions contributing to death but hot signed I 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has I autopsy perform death? certificate Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 00 Other: 1 🗌 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death n 24 hours after death.

Funeral Director: After the Select of Illed in by the funeral Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Tes 2 🗌 No Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. сотрые (Check within 24 Deryffying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatu d (Month/Day, Year)

3H-8

Registrar
DHMH 17 Rev 7/2009

State

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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	-	For State Registrar					-	rtificate of			-	Reg. No	$2  \mathrm{n}$ I	0	34073
Physicia Medic			D. Da	ıy							2. Date of Dea Month October	ath 12	201	Year	3. Time of Death 11:30 P M
Examin		4a. Facility Name (if 5005 Leito			and number,	)		4b. City, Town, o					County of		
Funeral	λ	5. Social Security N		6. Sex		ige (In yrs. la	ast birthday)	If Under 1 Year	If Unde	er 24 Hrs.	8. Date of Birt	:h		9. Birthp	place (State or Foreign
Director		434-56-457 Usual Residence of		1XX M 2	2 □ F	71	Yrs.	Months Days	Hours	Min.	02/10/1	<u>r939</u>		Utah	try)
yland -f shored at	ctor	10a. State	10b. County				y, Town or Lo							1	0d. Inside City Limits
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death ritem iner m	/ Fur	11. Marital Status		Ar	as Deceden med Forces	?		Was Decedent of H	lispanic C an, Mexic	Origin? (Spe an, Puerto I	cify Yes or No- Rican, etc.)		14. Race -	Americ White, e	
urs after tural", o	ted by	1 ☐ Never Marr 3 ☐ Widowed		l If	☐ Yes 2 ☐ Yes, Give ear or Dates.	XI No		1 ☐ Yes 2 XXNo	Specii	fy:			Specify:	Whi	
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e filed tal Hy ed oth event	To Be	17. Father's Name (		ast)							(First, Middle,	Maiden :	Sumame)		-
ould b nd Mei mark imark		Roy A. Day		ip (Tvpe, Pri	nt)		19h Mail	ing Address (Street		ia Dou		r City or	Town Sta	to Zin C	'odel
nd 2 sh salth ar n 27 is er trau		Delphine I						Leitches W							•
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disp 1 XX Burial 2 4 Donation	☐ Cremation	3 Remo	val from Sta	te C	emetery, cre	osition (Name of matory or other pla Highland	ce)	10/18	)ate /2010		cation - C		wn, State Maryland
rmit. P partme portar y injur		21. Signature of Fu						2. Name and Addre	ess of Fac		usch Fune				, ren yizuki
9 9 E 8 8		Kyle S.			1/	<b>*</b>	$\overline{}$	1405 Broomes		and Roa	d, Port I	Repub.	lic, M	aryla	and 20676
Physician/ Medical		23a. Part 1. Enter t shock, or hear Immediate Cause ( disease or condition resulting in death)	rt failure. List o (Final	complication only one cause a	ns that caus se on each li	ne.		ter the mode of dyir $ (-32) $							Approximate Interval Between Onset and Death
Examiner		roodking in dodain	1		Due to (or a	s a consequ	uence of):								
ed sit	Examiner	Sequentially list co if any, leading to in cause. Enter Under Cause (Disease or	nmediate rlving	Ь. —	Due to (or a	s a consequ	uence of):								
execut ian and irial-trar	al Exa	that initiated events resulting in death)	S	с. —	Due to (or a	s a consequ	uence of):						*	$\dashv$	
physici the bu	edice			d										+	
To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medic	IF FEMALE: 23b. Was decedent in the past 12 i 1 ☐ Yes 2 [ 9 ☐ Unknown	months?	1 4	yes, outcom □ Live Birth □ Pregnant □ Unknowr	n 2 ☐ Feta at time of c	al death 3	h 3  Ectopic pregnancy 5  Other (specify)					23d. Date of delivery Month Day Ye		
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tendin eath. or: Aft	Certificate:	1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide	5 ☐ Pendin- Investig 6 ☐ Could r	gation	(Month, E	ay, rear)	injury	M 1 .	k? Yes 2	□No					. <u>.</u>
al or Att s after d il Direct ed in by	Cert	4 Homicide	determi			njury - At ho etc. (Specify		reet, factory, office			28f. Location (S City or Tow			or Rural	Route Number,
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2	Medical	(Check 2	🖳 Medical E	xaminer: Or	the basis of	examination	n and/or inve	occured at the time stigation, in my opini death occurred at the	on, death	occurred at	the time, date a	nd place	, and due to	o the cau	use(s) and manner stated.
To th within To th	-	29b. Signature and		w	ath	N/		29c. Licens	e number			29d. Dat	te signed (	Month, L	Day, Year)
w 5		30. Name and addre	ess of person v	who complet	ed cause of	death (Item	23a) (Type,	Print)	B	~ ·	Da \ - :	>~ ·	·	y X	11/70
Stat Registra		31. Date filed (Mont	th, Day, Year)	150	32. Regis	trans Signat	ture	Print) EIVE fauls	ICLA	VCC T	IC DET	CICK		1 <u>0,</u>	00018
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_		Registrar  1. Decedent's Name (First, M	Aiddle Last	)			Certifica	ate of t	Jean -	2. D	ate of Dea	th		3. Time	of Death
Physicia		Salvatore									onth	Day	2010 Year	2:20	
/Medic		4a. Facility Name (If not insti	-						Location of Dea	ath			County of Deat		
		Frederick Vi						Caton:	sville	2   0 5	(D: 11		altimor		
Funeral Director		5. Social Security Number 212–62–7334		x 2 M 2□F	7. Age (In y		rs. Month		Hours Min	04/	ate of Birth Month, Day 18/1	Year) 926	9. Birt Co	hplace (State untry) Ita	
land ow		Usual Residence of Deceder 10a. State 10b. Co			10c.	City, Town	or Location							10d. Inside	City Limits
Mary a-f sh	ţo	MD				Balt	imore (	City						1 <b>X</b> Ye	s 2 No
or 28	Director	10e. Street and Number					10f.	Zip Code				10g. Citiz	en of What Co	untry?	
ath w		3611 White A	Avenue					2120					ed Stat		
and 2 should be filed within 72 hours after death with the Maryland patth and Mental Hygiene. n 27 is marked other than "natural", or items 23a or 28a-f show ler traumatic event, the Medical Examinar must be notified at	by Funeral	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☐</li><li>3 ☐ Widowed 4 ☑ Divo</li></ul>		12. Was Dec Armed Fo 1 ☐ Yes If Yes, G Year or I	2 ፟∰No ive	U.S.		cedent of H pecify Cuba 2 No	ispanic Origin? ( in, Mexican, Pue Specify:	Specify \ erto Rican	res or No- ı, etc.)		4. Race - Ame Black, White Specify: Wh	e, etc.	
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", any injury or other traumatic event, It is Medical Exagnes.	Completed	15. Dec (Specify only h Elementary/Secondary (0-		cation le completed) College (		16a.	Decedent's U (Give kind of life. DO NOT	work done o	lurina most of wo	orking	I	16b. Kin	d of Business/	Industry	
ed wit ygien er tha t, the	Con	4				M	anufac	turing					Clothin	ıg	
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should nd Me mark matic	၉	19a. Informant's Name/Rela		voe. Print)		19b.	Mailing Addre	ess (Street	and Number or F	-			Town, State, 2	Zip Code)	
and 2 saith al		Rosario Dil						,	derick F						21104
es 1 a of He of He If Item		20a. Method of Disposition  † Burial 2 ☐ Crema	tion 2 🗆	Domovol from		o. Place of cemeter	Disposition (f y, crematory c	Name of or other place	e) :	Date		20c. Loc	cation - City or	Town, State	
tment tment tant: I		4 Donation 5 Doth	er (Specify)	1	Cı	rest :			rdn.¦ 10/				riottsv		
permit Depar Impor any in		21. Signature of Funeral Se	rvice Licens	ee	M014	1/			<sup>ss of Facility</sup> Ha Columbia						
		23a. Part1. Inter the veas shock, or heart failure.	se, or comp List only o	lications that ne cause on	each line.				g, such as cardi	ac or res	piratory ar	rest,		Approxim Interval E Onset an	Between
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		a. Due to	or as a cons		Conte	5							
Examiner			- [	bue to	(or as a cons	equence o	,,,,								
it ed	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	,	Due to	(or as a cons	equence o	of):								
xecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last		C	(or as a cons	equence o	vf)·								
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s that I	by Ph	Part II. Other significant co	nditions co	ntributing to	death but not	resulting in	the underlyin	g cause giv	en in Part I.		23e. Did to	obacco us	se contribute to	the cause o	of death?
en sig	ed b		_							-	1 🗆 Y	es 2	No 3□P	robably 4	nknown
The law re cate has be page 2 sho	Completed									-			death?	utopsy finding completion o	
iclan: certific	Be	25. Was case referred to me examiner?	<b>⊢</b>	Hospital:				Oth	26. Place of D						
Phys or this oral dir	٩	1 ☐ Yes 2 ☐ No 27. Manner of Death		1	Inpatient 2 of Injury		tpatient 3 🗆	28c. Injur	er: 4 Nursing				Other (Spe	ecify)	
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To the To the Comp	Me	29b. Signature and title of co		z 4				29c. Licens				29d. Dat	e signed (Mon	th, Day, Year	)
		30. Name and add ess of pe	roon who o	omploted car	MS use of death (	Item 23a) (	(Type, Print)		7683			10	13/10		
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Examin	er		_	ive street and number)				n, or Location of E	eath		County of Death	
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Funeral Director		217-28-		1₽ M 2□ F	79		Months Da		Min. (Month, L	Dav. Year)	931 Mary	ntry)
σ		Usual Residence of	f Decedent						00011			
arylar show	_	10a. State	10b. County		10c. City,	Town or Lo	ocation				1	0d. Inside City Limits
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fter d	Fun		ried 2K Married	Armed Forces? 1 14 Yes 2 □	No Kore	ALI			? (Specify Yes or Nuerto Rican, etc.)	- 1	Black, White,	etc.
ral", o	by	3 Widowed	4 Divorced	If Yes, Give Year or Dates:			1 □Yes 2X	No Specify:		1	Specify:Blac	CK .
72 hc	Completed	(Spec	15. Decedent's cify only highest of	Education prade completed)			dent's Usual O	cupation one during most of	working	16b. Kii	nd of Business/In	dustry
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2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene, and Mental Hygiene is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examinations to notified a	F	19a. Informant's N				19b. Mailii	ng Address (St		or Rural Route Num			Code)
alth a 27 is		Kathleen	F. Duff	v/ Wife					erlin, Ma			,
of He		20a. Method of Dis	position	•	20b. Pla	ace of Dispo	osition (Name of matory or other	f i	Date	1-4	cation - City or To	own, State
Page nent ant: If ury ol			☐ Cremation 3 5 ☐ Other (Spec	☐ Removal from State cify)			el UMC (		/16/2010	Ber	lin. Mar	vland
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination in the motified at once.		21. Signature of Fu	uneral Service Lic	ensee	,			Idress of Facility			Maryland	
2011		rais	ella	U. Soll	en_						Jersey	Road 21801
Physician /Medical		23a. Part1, Enter t shock, or hea Immediate Cause disease or condition resulting in death)	(Final	mplications hat caused ly one calle on each li a.	th death. ne.	Do not en	ter the mode of	dying, such as ca	rdiac or respiratory	arrest,		Approximate Interval Between Onset and Death
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requii	ted		- 1/670	1190					_   1	Yes 2	□ No 3□ Pro	babiy 4 Unknown
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r: The icate									per 1 □ Yes	formed? 2 X No	death? 1 ☐ Yes	2 🗆 No
siciar certif rector	Be	25. Was case refer examiner?	/	Hospital:				O45	Death (Check only	·		
Phys	5	1 ☐ Yes 2 🔀 27. Manner of Deat	`	1 L Inpati		R/Outpatie 28b. Time o	nt 3 DOA	4 LI Nursi	ng Home 5 Re			(fy)
nding th. : Afte e fune	ţi	1 Natural 2 Accident	5 Pending investigat	28a. Date of Inju (Month, Date)	ıy, Year)	Injury		njury at Work? 1 □ Yes 2 □ No			,	
Atter	ifica	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not determine	28e. Place of In	ury - At hon	ne, farm, str	reet, factory, off	ce				al Route Number,
al or s afte al Dir	Certification: To	4 🗀 Homicige		building, et	c.*(Specify)				City or I	own, State	)	
	Medical	29a. Certifier (Check only one)	1 X Certifying 2 Medical Ex	Physician: To the best aminer: On the basis of and manner st	of examination	rledge, deat on and/or ir	th occurred at the occurred at	ne time, date and ny opinion, death	place, and due to the occurred at the time	ne cause(s e, date and	) and manner as I place, and due	stated. to the cause(s)
withii To the	ĭ	29b. Signature and	title of certifier	11	4		l.	ense number		29d. Dat	te signed (Month	Day, Year)
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1998		30. Name and add	ress of person wh	completed cause of	leath (Item :	23а) (Туре,	Print)	4 0	• • • • • •	1 :	. 15	) (C. 1.1
Star	e	31. Date filed (Mor	nth, Day, Year)	Yzalez, r	1D 3 ar's Signatu	14 fr	anklin	HVe. 34	e 104, Be	riiri,	MU 2	!/& / /
Registra			OCT 15		~ /	1. 6	and					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 1502 Physician/ Ellwanger Elizabeth 2010 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** CRIMEN Baltimore Baltimore University of Maryland Medical If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 07/09/1955 1 □ M 2 🗓 F Months 55 Director 218-48-5181 Usual Residence of Decedent 10d. Inside City Limits or 28a-f shov 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 Tes 2 No Greensboro Caroline 10f. Zip Code 10g. Citizen of What Country? Funeral 21639 United States 11831 Knife Box Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Race - American Indian. 11. Marital Status 1 X Never Married 2 ☐ Married Completed by Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Farming <u>Agriculture</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Charles L. Ellwanger Mary Margaret Gardner Ellwange: 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11831 Knife Box Rd, Greensboro, MD 21639 Sara E. Bennett 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Greensboro Cemetery 10/21/10 Greensboro, MD 22. Name and Address of Facility 106 W. Sunset Ave., Greensboro MD Signature of Funeral Service Fleegle & Helfenbein Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition Physician/ Astration Medical resulting in death) Due to (or as a consequence of) cholangiocavcinoma Examiner Metastatic Sequentially list conditions if any leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Fruneral Director After this certificate has been signed by the attending neural named to the attending neural bureator. Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year 5 Other (specify) To the Funeral Director; After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ cardiopulmonary arrest 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical Be 1 Yes Other: 2 🗷 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cert 10 - 15 - 2010 MT 195404 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD Fitzgerald 11 5. Greene Karıma 31. Date filed (Month, Day Year) ar's Signature State Registrar

DHMH 17 Rev 7/2009

			Please	Type or Pri							Legible.		
		ŀ	For State	State of Ma	aryland /				nd Mental Hy	/giene	0010		
			Registrar  1. Decedent's Name (First, Middle, Las	(t)		Cen	ificate of D	<i>Jeatn</i>	2. Date of D	Reg. No.	2010	340	77
Н	Physicia		Claire DeSil	,	owler				Octobe		2010 <sup>Year</sup>	3. Time of Deal 3:15 P.	
	Medio Examin		4a. Facility Name (if not institution, give				4b. City, Town, or	Location of D			County of Death	3.13 1.	
	pd .		Calvert County N	ursing Cer	nter			e Fred			Cal <sub>v</sub>	ert	
	Funeral Director		5. Social Security Number 6. Se 579–36–3930 1  Usual Residence of Decedent	ex	e (In yrs. last bi 86		If Under 1 Year Months Days			rth 171924	9. Birthp Coun Penn	place (State or For try) Sylvania	reign
	at at	or	10a. State 10b. County		10c. City, Tov	wn or Loca	ation				1	0d. Inside City Lin	mits
	Maryla 18a-f	Director	MD Calvert		Pri	ince	Frederic	k				1 🗆 Yes 2 🛚	ŌΝο
	a or 2		10e. Street and Number				10f. Zip Code			10g. Citiz	zen of What Cour	itry?	
	h with	Funeral	85 Hospital Road				<del></del>	20678			U.S.A.		
	r deat r iten iner r		11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces?		13. W	as Decedent of Hi Yes, specify Cuba	spanic Origin n, Mexican, P	? (Specify Yes or No Juerto Rican, etc.)	. 1	4. Race - Americ Black, White,		
036	s afte 'al", c	d by	3 X Widowed 4 Divorced	1 Yes 2X If Yes, Give X Year or Dates.	No	1	☐ Yes 2 <b>X</b> No	Specify:		s		ite	
2-0	hour natur dical	Completed	15. Decedent's Ed	ducation	16		nt's Usual Occupa			16b. Kir	nd of Business Inc	dustry	
21	nin 72 Je. Than " e Med	omp	(Specify only highest gra	College (1-4 or 5	+)	life. DO	nd of work done a NOT use retired)		f working	١,,	7.1.	1	
121	d with	Be C	11 17. Father's Name (First, Middle, Last)			cre	dit mana				lding su	іррту	
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To E	Edward Crock	er					s Name (First, Middle she1 G		Miller		
Mar	2 shouth and the nd is not is		19a. Informant's Name/Relationship (Ty						or Rural Route Numb			Code)	
é,	and Healt Healt tem 2		Roberta A. Biggs, 20a. Method of Disposition	daugnter			tion (Name of	ive, H	untingtow	_	20639 cation - City or To	uun Ptoto	
JOL	age 1 ent of nt: If ii		1 ☐ Burial 2 🔀 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐ Other (Specification 5)	Removal from State	cemet	tery, crema	atory or other place		10/11/10		xandria,		
Baltimore,	mit. P partm portar portar / injur	-	21. Signature of Funeral Service Licens		Inerro				Rausch Fu				$\dashv$
m	Der Der One		1 Duna	Tello	ach				y Lane, 0			0736	
-	Physician/ Medical Examiner	er	23a. Part 1. Enter the disease, or companies shock, or hear failure. List only or immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	a. Due to (or as a	SPCT.	of):	Heave the mode of dying	g, such as car	a Twe	rrest,		Approximate Interval Between Onset and Death	
09/	ath certificate be executed attending physician and for use as the burial-transit	ledical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	C. Due to (or as a d.									
). Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of Live Birth 24 Pregnant at 9 Unknown	2 🗌 Fetal dea		Ectopic pregnanc Other (specify)	у		2	3d. Date of delive	ery Day Year	
P.0.	that the	by P	Part II. Other significant conditions co	intributing to death bu	ut not resulting	g in the un	derlying cause giv	en in Part I.	23e. Did	tobacco us	e contribute to th	e cause of death?	?
ds,	quires en sig ould b	ted	COPD						1 🗆	Yes 2	No 3 ☐ Prob	pably 4 Unkn	iown
COL	aw re las be	nple							24a. Was		24b. Were autop	osy findings availa	ble of
Re	cate h								perf 1 🗌 Yes	ormed?	death? 1 ☐ Yes	2 🗆 No	
ita	sician: The law certificate has b lirector, page 2 s	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital:			Otho		(Check only one)				
<u></u>	Phys r this eral di	e: To	27. Manner of Death	1 ☐ Inpatie 28a. Date of injur	nt 2 ER/C	Outpatient Time of	3 L DOA	4 LA Nursi	ing Home 5 Resi			)	
ou c	nding ath. r: Afte e fun	icat	1 Alatural 5 Pending 2 Accident Investigation	(Month, Day,	Year)	injury	work'	? Yes 2□No		now injury	occurred		
Division of Vital Records,	To the Hospital or Attending Physician: The Is within 24 hours after death.  To the Funeral Director: After this certificate his completed filled in by the funeral director, page	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injui building, etc.		farm, stree	t, factory, office		28f. Location ( City or To		Number or Rural	Route Number,	
	To the Hospital within 24 hours a To the Funeral I completed filled	Medical	29a. Certifier 1 Certifying Phys (Check 2 Medical Examinonly one) 3 Certifying Mass	sician; To the best of r	amination and	or investic	ation, in my opinio	n. death occur	rred at the time, date	and place.	and due to the car	ise(s) and manner s	stated.
	To the To the Comp	2	29b. Signature and title of certifier	e i lactionet. lo tho E			29c. License	number		29d. Date	signed (Month, L	Day, Year)	$\dashv$
			1/6	MD			DS	194	9	/	0/11/10		
1	au) 2		30. Name and address of person who	ômpleted cause of de	eath (Item 23a)	(Type, Pri	nt) 1 11	- 4 -	9 Prince		111	444 200	
di	RW 3		21 Date filed (Marth Day York)	Sallam	110 H	ospi	BIKA, S	Unde 3	10 Prince	e fre	derik,	MD 206	78
	Stat Registra		31. Date filed (Month, Day, Year) OCT 1	2 2010 2	s Signature	S.	backer						

	a CAMETA ILEM I/	artment of Health and Mental rtificate of Death	Hygiene 2010 34078
Physician	1. Decedent's Name (First, Middle, Last) Edith Deane Grove	2. Date Mont OC	of Death 3. Time of Death
/Medical Examiner	4a. Facility Name (If not institution, give street and number) Homewood Retirement Center	4b. City, Town, or Location of Death Williamsport	4c. County of Death Washington
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 236-28-6187 1□ M 梁 F 94 Yrs.	If Under 1 Year If Under 24 Hrs. 8. Date (Months Days Hours Min. 9 – 6	of Birth th, Day, Year) -1916  9. Birthplace (State or Foreign Country) Inwood, WV
show	Usual Residence of Decedent   10a. State   10b. County   10c. City, Town or Lo   MD   Washington   William	ocation	10d. Inside City Limits 1 □ Yes 2 ☑ No
with the M 3a or 28a-1 It be notified	10e. Street and Number 16505 Virginia Ave.	10f. Zip Code 21795	10g. Citizen of What Country? U.S.A.
Baltimore, Maryland 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, if a Marical Exercitant country or other event, if a Marical Exercitant country or other events of the Exercitant country or other events of the Exercitant country or other events or other events of the Exercitant country or ot	Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No	Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, et 1 □Yes	or No- c.)  14. Race - American Indian, Black, White, etc. Specify: White
21215-0036 d within 72 hours aft glene. er than "natural", or if the Medical Exercit Completed by F	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working DO NOT use retired) .ursing	16b. Kind of Business/Industry home duty
/land ; uld be filec Wental Hyg Wental Hyg intic event,	17. Father's Name (First, Middle, Last) Edward Holmes Custer ward Holmes Custer	18. Mother's Name (First, M Bernice G	diddle, Maiden Surname) lover Custer
, Mary and 2 sho ealth and I n 27 is me her traume		ng Address (Street and Number or Rural Route I Vaquero Dr. Martins	
altimore, Maryland mit. Pages 1 and 2 should be file partment of Health and Mental Hy portant; If Item 27 is marked othe y Injury or other traumatic event, ce.	20a. Method of Disposition  1 ☐ Burial 2 ▼Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)	usition (Name of natory or other place) natory or other place) oct 2010	20c. Location - City or Town, State Smithsburg MD
Balt permit Depar Import any in	D D	2. Name and Address of Facility Conald Edwin Thomps 2. O. BOX 310 Clear S	on Funeral Home, Inc
Physician // // // // // // // // // // // // //	23a. Part 1. Enter the disease, or complications that eaused the death. Do not ent shock, or heart failure. List only one cause of dach line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	ter the mode of dying, such as cardiac or respira	Ory arrest, Approximate Interval Between Onser and Death
Examiner 5	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury)		
8760, cate be executed physician and the burial-transit dical Examine	Cause (Disease or injury that initiated events c. That initiated events resulting in death) Last c. Due to (or as a consequence of):		
	d		
the cy the ched	in the past 12 months?	□ Ectopic pregnancy □ Other (specify)	23d. Date of delivery  Month Day Year
cords, P. w requires that w requires that should be detacted by Princetory of the control of the	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I. 23e.	Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
Vital Record stelan: The law require certificate has been si irector, page 2 should Be Completed I	Haraterson Densent	<i>1</i>	Was an autopsy performed?  Yes 2 ♥ No 1 □ Yes 2 □ No
F Vital yslclan: T is certifical director, pi	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien	26. Place of Death (Check	
Division of Vita to Attending Physician: after death. Director: After this certification by the funeral director. ertification: To Be (	27. Manper of Death  1 Natural 5 Pending (Month, Day, Year)  2 Accident investigation		cribe how injury occurred
Division of Hospital or Attending Phys n 24 hours after death.  Per Funeral Director: After this bletely filled in by the funeral director.  Grant Certification: To edical Certification: To	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office 28f. Loca City	tion (Street and Number or Rural Route Number, or Town, State)
To the Hospit within 24 hour To the Funer completely fillimage.	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, deat and manner stated.	h occurred at the time, date and place, and due exestigation, in my opinion, death occurred at the	to the cause(s) and manner as stated. time, date and place, and due to the cause(s)
To the within common common MM	29b. Signalus apertite of pertifier  MEDICAL MINISTRA	29c. License number	29d. Date \$igned (Month, Day, Year)
1-H0	30. Name and address & person who completed cause of death (Item 23a) (Type,	Print Pa Aug, TElOI H	margreen, Uld 21742
State Registrar	31. Date filed (Month, Day, Year) OCT 2 2 2010 32. Registrar's Signature	Sac	

10-08064 Grant Alexande	r Gr	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  State of Maryland / Department of Health and Mental Hygiene
		1- For State Registrar Certificate of Death Reg. No. 2010 340
Physici Medical Exam		Grant Alexander Gruzenski October 20, 2010 Tear 1430 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel
Funeral Director		5. Social Securify Number 215–92–3714  6. Sex 1   7. Age (In yrs. last birthday) 32   8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Marryland Country) 19. Birthplace (Stat
w any		Usual Residence of Decedent  10a. State
Oyland sa-f sho	ctor	MD Queen Anne's Centreville 1 Yes 2 XN  10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
he Ma	Director	250 Concerto Avenue 21617 USA
ath with t tems 23a st be not	Funeral	11. Marital Status 1
7 — 2 O F 72 hours after death with the Maryland n "matural", or items 23a or 28a-f she al Examiner must be notified at once	by Fu	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done)  16b. Kind of Business/Industry
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by	Elementary/Secondary (0-12)  College (1-4 or 5+)  Contractor  Contractor  College (1-2 or 5+)  Contractor  Contractor  Telecommunications
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Som	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)
215 be file ntal H- rked o	Be	Dale Gruzenski Cheryl Pegues
D 21 should and Me	7	
MD and 2 sho lealth and tem 27 is		Mandie Gruzenski / Wife   250 Concerto Avenue Centreville, MD 21617   20a. Method of Disposition   20b. Place of Disposition (Name of cemetery, Date   20c. Location - City or Town, State
Baltimore, permit. Pages 1 at Department of Hee Important: If ite		1 X Burial 2 Cremation 3 Removal from State Meadowridge Memorial Cotober 25 Elkridge, MD Park
Balt permit. Departu Import		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Hom
Physician		1495 Ritchie Hwy, Severna Park, MD 21146  23a. Part I. Enterche disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interview Between Onset and Between Onset an
/Medical Examiner		failure. List only one cause on each line.  Immediate Cause (Final disease a. <b>Methadone Intoxication</b> Between Onset an Death
ZAMINIO		or condition resulting in death)  Due to (or as a consequence of):
	ıer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):
	kamine	cause. Enter Underlying Cause (Disease or injury that initiated  c. Due to (or as a consequence of):
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cial rial	dica	x UNPENDED 23a,27,28a-f per me g909 11-10-10 vt
68760, certificate be nding physicilise as the buri	n/Me	IF FEMALE: 23b. Vast 40 greaths 2 gr
ox cath	Physician/Medical	past 12 months?  4 Pregnant at time of death  5 Other (Specify)  9 Unknown  9 Unknown
tal Records, P.O. Box cian: The law requires that the death certificate has been signed by the atte ector, page 2 should be detached for u	þ	1 Yes 2 No 3 Probably 4 🗸 Unknown
cords, aw requir has been si 2 should b	Completed	24a. Was an autopsy findings availab autopsy prior to completion of cause of performed?
tal Rec ician: The l certificate I	Con	1 ✓ Yes 2 No 1 ✓ Yes 2 No
Vital hysician: this certi	o Be	
of \\ ing Phy After th funeral	_	27 Manner of Death 28a Date of Injury 28h Time of Injury 28c Injury at Work? 28d Describe how injury occurred
ion tendir tor: A the fu	atior	Natural 5 Pending Investigation Accident Properties of the state of th
Division of Vital   To the Hospital or Attending Physician: within 24 hours after death. To the Funcral Director: After this certif completely filled in by the funcral director.	Certification:	3 Suicide 6 St Could not be control of the suicide
Dospital hours		
To the Ho within 24 To the Fu	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
Fo Form	e	and manner stated.

To the Hos within 24 h
To the Fun completely

State 31. Date filed (Month, Pay Year) 5 2010 Registrar

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifier

Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year)

October 21, 2010

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene

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		1- For State Certificate of Death Reg. No.											
Physic		1. Decedent's Name (First, Midd	ath Y	3. Time of Death									
Medical Exam	iner	Alexis Ann Ge	evins					Month October 1	Day Yea 18, 2010	1134 hrs			
1		4a. Facility Name (if not institution	on, give street and n	umber)	4	b. City, Town, or L	ocation of Death		4c. County of	of Death			
		3911 8th Street			İ	Brooklyn			Balti	more City			
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. las	st birthday)	If Under 1 Year	If Under 24Hrs	8. Date of Bi	irth (MM/DD/YYYY	9. Birthplace (State or			
Director		212-04-0977	1 M 2 X F	3	O v	Months Days	Hours Min	12/2/	1070	Foreign Country) OR			
	1		I M ZAF		U Yrs.	ll		12/2/	1979	Codinity) UK			
any		Usual Residence of Decedent  10a. State 10b. County		10c City T	Town or Location	in .				10d. Inside City Limits			
<b>*</b> ,		Manual - 1								1 X Yes 2 No			
aryland 8a-f show at once.	후	Maryland Balti	more City		baltim	ore City							
Mary Mary	Director	10e. Street and Number				10f. Zip Code		[	10g. Citizen of Wh	at Country?			
T C P 72 hours after death with the Maryland n"natural", or items 23a or 28a-f sho al Examiner must be notified at once.	ﻕ	3911 8th Str	eet			21225			U.S.A.				
ms 2	Funeral	11. Marital Status		cedent Ever in U.S.		Decedent of Hisp				- American Indian, Black,			
rite death	Ē	1 X Never Married 2 M	arried Armed F	2 X No	ITYE	s, specify Cuban,	Mexican, Puerto	Rican, etc.)	White	, etc.			
Ther iffer		3 Widowed 4 Div	orced If Yes, Give Ye		1 🗌	Yes 2 X No	specify:		Specify:	White			
atura anima	Completed by	15. Decedent's Education (Spe-		de completed) 1		s Usual Occupation			16b. Kind of Bus	siness/Industry			
72 ho	et	Elementary/Secondary (0-12)	College (	1-4 or 5+)	during mo	st of working life. I	DO NOT use reti	red)					
thin than than than than	ם	10				none				none			
5-0 ed wi sygies of the M	ပ္ပြဲ	17. Father's Name (First, Middle,	Last)			18	8.Mother's Name	(First, Middle,	Maiden Surname)				
21215-0036 Mental Hygiene Mental Hygiene marked other than "natural c event, the Medical Examin	Be	Allan J. Gevi	ins				Laura G	ale (un	known)				
<b>(1</b> ∃ ≥ € 0	2	19a. Informant's Name/Relations			19b. Mailing					n, State, Zip Code)			
MD and 2 shoulth and m 27 is aumatis	Ι΄.	Donald Richard	son / PR		27441	Wright's	Post I	ano Fa	ston, Ma	rvland 21601			
		20a. Method of Disposition	-		ace of Disposit	on (Name of ceme	etery,	Date La	20c. Location -	City or Town, State			
nore, Nages 1 and nt of Healti		1 Burial 2 X Cremation	ı 3 ☐ Removal f	rom State	ematory or othe		_ 10/	20/10					
timen rtant		4 Donation 5 Other Sp		raii		hurch Ce				a, Maryland			
Baltimore, permit. Pages 1 at Department of He Important: If ite injury or other tr		21 Signature of Funeral Service							eral Home				
		Kandopht	1 leux							Maryland 21629			
Physician /Medical		23a. Part I. Enter the disease, or failure. List only one cause	on each line.			mode of dying, si	uch as cardiac o	r respiratory arr	est, shock, or hea	rt Approximate Interval Between Onset and			
Examiner		Immediate Cause (Final disease											
7		or condition resulting in death)	Due to (or as a	consequence of):			_						
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	Examiner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a	a consequence of):									
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8760, ifficate be executed by physician and is the burial - transit	Physician/Medical	X UNPENDED	AMENDED	27 20- 5	Mi	7 (000 11	1/5/10 7	ım					
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<b>∞</b> :=	2	23b. Was decedent pregnant in th		outcome of pregna pirth		Ideath 3	Ectopic pregna	ncv	23d. Date of d Month	Day Year			
Sox 68 leath certi e attendin for use as	cia	past 12 months?	4 Pregr	ant at time of death	h =	(Specify)		,		July 1001			
Box 68 c death cert the attendir	ıys	1 Yes 2 No 9 V Unk	nown 9 Unkn	own									
		Part II. Other significant conditi	ons contributing to	o death but not resu	ulting in the un	derlying cause giv	en in Part I.	23e. Did to	obacco use contrib	oute to the cause of death?			
i, P.O.	ğ							1 Yes	2 No 3	Probably 4 V Unknown			
ords, w requir is been s	Completed by	ų						24a. Was	an   24b. W	ere autopsy findings available			
COT law r has b	힏			_				autop	sy pr	ior to completion of cause of eath?			
Re The icate page	녌							1 Yes		Yes 2 No			
tal Rec ician: The certificate rector, page	Be (	25. Was case referred to medical examiner?					f Death (Check o	nly one)					
of Vital Records, By Physician: The law requir ufter this certificate has been s meral director, page 2 should	9	1 ✓ Yes 2 No	Hospital: 1	Inpatient 2 El	R/Outpatient	3 DOA 01	ther Nursing	Home 5	Residence 6 🗸	Other: Scene			
n of Jing Ph	Ë	27. Manner of Death	28a. Date (Month	of Injury 2	8b. Time of Inju	ury 28c. Injury	at Work?	28d. Describe t unk	now injury occurre	d			
Division tal or Attendir ts after death.	ertification	1 Natural 5 Pending Fd 10/18/10 Fd 11:20 am 1 Yes 2 No											
/isal	fic	- v	not be	e of Injury - At hom single f	e, farm, street,	factory, office buil	lding, etc.	28f. Location (S	Street and Number	or Rural Route Number, City			
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that th within 24 hours after death.  To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detach	ert		mined (Specify)	single I	amily	reslaence	9	Brookly	itate) 3911 8	stn St			
Hosp 24 hor Fune	2	29a Cortifier	ysician: To the bes	st of my knowledge.	, death occurre	d at the time, date	and place, and			as stated			
To the Hos within 24 h To the Fun	흥		niner: On the basis	of examination and									
To Wit	Medical	29b. Signature and title of certifie	and manner s	tated.		29c. License r	number	-	29d. Date signed	(Month, Day, Year)			
	-	1	1/12 00			O.C.M.			October 19,				
	ļ	arat	Hall			J.J.IVI.			00.0001 13,	2010			
		30. Name and address of person				root Dalkinsen	- MD 24204						
- 11		· · · · · · · · · · · · · · · · · · ·	sistant Medical			reet, Baltimor	e, IVID 21201						
St Regis		31. Date filed (Month, Day, Year)	010	gistrar's Signature	park	1							
- Negis	are.II	OCT 2 7 2	LILL ENGINEER	iem jes.	4.7								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10/10/201 Charles Franklin Hardman 5:00 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Calvert 1675 Kings Landing Road Huntingtown Social Security Number If Under 1 Year | If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country) . Age (In yrs. last birthday) **Funeral** Months Min 1 X M 2 🗆 F Days Hours 06/08/1944 Yrs. Director 66 236-66-4318 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Calvert Huntingtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1675 Kings Landing Road 20639 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ð Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) should be filed within 72 and Mental Hygiene. 7 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) 12 Carpenter Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မှ Roy S. Hardman Maude E. Howes permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Hardman / Son 10167 Guilford Road, Jessup, MD 20794 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 X Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Bailey Cemetery 10/16/2010 Buckhannon, WV 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. Lisa M. Mounts 8125 Southern Maryland Blvd., Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Lung Cancer Years disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-transit Cause (Disease or illinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an within 24 hours after death.

To the Funeral Director: After this certificate has performed? Yes 2 No 2 No 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4  $\square$  Nursing Home 5 X Residence 6  $\square$  Other (Specify) 1 Yes 2 🗶 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate; 28c. Injury at 28d. Describe how injury occurred injury 5  $\square$  Pending X Natural Accident work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗍 only one 29b. Signature and title of cer 29c. License number 29d. Date signed (Month. Day, Year)

dRW 15

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Arati Patel, 110 Hospital Road, Ste. 212, Prince Frederick, MD 20678

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra s Signature

D0059061

October 12, 2010

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10:05P M October James Hilmer Hanson 16, 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Williamsport Nursing Home Williamsport Washington 8. Date of Birth (Month, Day, Ye, 6/7/1925 **Funeral** Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 1 XM 2 □ F Hours Director 027-18-8807 85 Massachusetts Usual Residence of Decedent or 28a-f show ä 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 Tes 2 No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 19219 Rock Maple Dr. U.S.A. 21742 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. or. ģ 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: "natural", Completed Specify: 3 Widowed 4 Divorced White Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 12 Printer Publishing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hilmer James Hanson Edla Lundgren 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irene E. Hanson / Wife 19219 Rock Maple Dr. Hagerstown Maryland 21742 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of I Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Rest Haven Cemetery 10/20/2010 Hagerstown Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityRest Haven Funeral Chapel 601 Pennsylvania Ave. Hagerstown Maryland 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): inding physician use as the burial Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be funeral director 26. Place of Death (Check only one) examiner? Other: ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 24 hours after death. Funeral Director: A 2 🗌 No 2 Accident
3 Suicide
4 Homicide the 1 Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 7

State Registrar

SH-0+1

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

DHMH 17 Rev 7/2009

is of person who completed cause of death (Item 23a) (Type, Print)

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			for State Registrar	State of Mi	-	epartment of r Certificate of		Reg. 1	/ !! i !!	34083
	Physici	an	1. Decedent's Name (First, Middle	Last)					Day Year	3. Time of Death
100	/Medic		Mavis C. Horner					CTOBER	12,201	
	Examin	er	4a. Facility Name (If not institution, Sunrise of Seven				r Location of Death everna Park		4c. County of Dea Anne A	
	F				e (In yrs. last birth			-		
	Funeral Director		252–36–5195 Usual Residence of Decedent	1  M 2	90 Y		Hours Min.	B. Date of Birth (Month, Day, Yea 5/20/192	0 C	rthplace (State or Foreign ountry)  Georgia
	land ow		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	Mary a-f sh	ģ	MD Anne A	rundel		Arnold				1 ☐ Yes 21 No
	or 28;	jre	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	ountry?
	23a (23a ust b	<u>ra</u>	1464 Bay Green	Dr.			21012		USA	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show may injury or other traumatic event, it. It. Item Event in a rust be notified an once.	by Funeral Director	11. Marital Status  1 Never Married 2 Marrie  3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 25 If Yes, Give Year or Dates:		13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2√√No	dispanic Origin? (Spec an, Mexican, Puerto Ri Specify:	ify Yes or No- ican, etc.)	14. Race - Am Black, Whit Specify:	
2-0	2 hou	Completed by	15. Decedent' (Specify only highes	s Education	16a. [	Pecedent's Usual Occup	pation	16b.	Kind of Business	/Industry
21	thin 7 ne. nan "r	nple	Elementary/Secondary (0-12)	College (1-4or 5	o+)	Give kind of work done ife. DO NOT use retire	d)	i		
	should be filed within and Mental Hygiene. is marked other than aumatic event, the manatic event event, the manatic event event, the manatic event			4	H	omemaker	40.44.11.1.314		Own Home	
and	be fill he de fill he de otter ever	Be	17. Father's Name (First, Middle, L				18. Mother's Name (			
Maryland	hould nd Me mark matic	은	Leonard Lee Coop  19a. Informant's Name/Relationsh		19h F	Mailing Address (Street	Rebecca F			Zin Code
Z	nd 2 suith ar	9	Margaret Horner	Daughter		4 Bay Green				_,, 0000)
re,	s 1 and 2 of Health item 27 i		20a. Method of Disposition			Disposition (Name of crematory or other place			Location - City or	Town, State
E	Page nent c int: If		★▼ Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp	3 ☐ Removal from State ecify)		dy of Sorre	i	5/10 We	st River	, MD
Baltimore,	permit. Pages 1 Department of H Important: If ite any Injury or ot once.	y P	21. Signature of Funeral Service I		1	22. Name and Addre	ess of Facility Hard	lesty Fun	eral Hom	
			23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that caused only one cause on each li	the death. Do no				21,01	Approximate Interval Between
5	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Due to (or as	a consequence of	TIA		,		Onset and Death
	Examiner	-	Sequentially list conditions,	b						
	ted nsit	njue	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of	:				
	execu n and al-trar	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as	a consequence of	:				
68760,	rificate be executed ig physician and as the burial-transit	ledical		d						
	ng ph		IF FEMALE:							
P.O. Box	The law requires that the death cert ate has been signed by the attendin, bage 2 should be detached for use a	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1  Live birth 4  Pregnant a	2 Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	су		23d. Date of de Month	elivery Day Year
	s that ined b e deta	by Pr	Part II. Other significant conditio	ns contributing to death b	ut not resulting in t	he underlying cause giv	ven in Part I.	23e. Did tobaco	co use contribute t	to the cause of death?
īd	v requires been sign should be							1 ☐ Yes	2 No 3 □ F	Probably 4 Unknown
Vital Records,	: The law requ cate has been page 2 shoul	Completed						24a. Was an autopsy performed 1 □ Yes 2 □	prior to death?	autopsy findings available ocompletion of cause of
/ita	Physician: The rthis certificate ral director, page	Be	25. Was case referred to medical examiner?				26. Place of Death		A c	
of \	Physion this call dire	၉	1 ☐ Yes 🎾 No		ent 2 ER/Outp	attent 3 L DOA		e 5 Residence		ecify)
	ling After fune	ion	27. Manner of Death 1 ✓ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28b. Tii y, <i>Year)</i> Inj	ury Voi	rk?	3d. Describe how in	njurý occurred	
Division	Atten r deat ector: by the	Certification:	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ot be 28e. Place of Inj	ury - At home, farn c. (Specify)	n, street, factory, office	]Yes 2 □ No	Bf. Location (Street City or Town, St	t and Number or F tate)	Rural Route Number,
	the Hospital or hin 24 hours afte the Funeral Dir mpletely filled in	Medical C		g Physician: To the best examiner: On the basis of and manner st	of examination and ated.	or investigation, in my	opinion, death occurre	d at the time, date	and place, and du	ue to the cause(s)
	To the within To the Comp	M	29b. Signature and title of certifier			29c. Licens	se number	29d.	Date signed (Mor	nth, Day, Year)
			msneg	ms		D5	7531	Oc	tober 1	3,2010
	1410		30. Name and address of person which we ga	who completed cause of a 8 50 1 Vc. 32. Registr	leath (Item 23a) (T	ype, Print) Huy ~	illersoil	le mi	2110	8
Í	Sta Registr		31. Date filed (Month, Day Vear) OCT 1	4 2010 32. Registr	rar's Signature	pares				

State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 8 2<u>010</u> Physician/ HOFFMAN Month October 11:01 PM M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Morningside House Assisted Living Prince Georges Laurel 5. Social Security Number If Under 24 Hrs Date of Day, Year) (Month, Day, Year) 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Months Hours Min. Director Feb.26 New York 050-20-3899 Usual Residence of Decedent on any defense the state of the 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 🗆 Yes 2 ⋤ No Maryland 1 4 1 Prince Georges Laurel 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral 7700 Cherry Lane 20707 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married filed within 72 hours after Yes 2 No f Yes, Give Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: Completed 3 X Widowed 4 Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed, Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Government Enigneer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be file Department of Health and Mental P Important: If item 27 is marked o any injury or other traumatic even once. ည Rose Dubrow Harold Hoffman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4401 Morningwood Drive, Olney, Maryland 20832 Irene Manford - Daughter Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 10/12/2010 Laurel, Maryland Baltimore Washington Crem. 22. Name and Address of Facility Fleck Funeral Home, Inc. Signature of Funeral Sentice Livens 7601 Sandy Spring Road, Laurel, Maryland 20707 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ emen disease or condition resulting in death) nknown Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 1 Yes 2 L 9 Unknown g Unknown P.O. þ Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Was an autopsy performed? 2 🗌 No 1 Yes of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) ASSISTED 1 Yes 2 × No မ 1 Inpatient 2 ER/Outpatient 3 DOA LIVING 4 ☐ Nursing Home 5 ☐ Residence 6 🔀 Other (Specify 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Matural Natural 5 Pending Division 1 Yes Accident
Suicide
Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a To the Funeral C Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Rita Dhawan 10/11/2010 D0062534 9055 Cherrolet Sr, Suite 103, Ellicoft City, Mb-21042 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar amend 24a per Dr. g908 10/29Cettificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician san nninas /Medical 4a. Facility Name (If not institution, dive street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JEUTGIE navery rince George ς Hospital enter MINCE If Under 1 Year | If Under 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Min. Year) NIA Maryland Director 9-25-10 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f si any injury or other traumatic event, the Modeal Examine must be not lithed Prince Georges Capitol 1XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 20743 902 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2 XNo Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) atant LINFANT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be charles Edward Anthony bnella Mae Jehnings 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 57th Janella Jennings Hace Capital Heights, ND 20743 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cheverly, MD 4 Donation 5 DiOther (Specify) Hosp Di50 10-15-10 Prince Georges Hospital 22. Name and Address of Facility Prince Georges Hospital Centr 3001 Hospital De Cheverly 21. Signature of Faheral Service Ucensee MI MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final dus HUSS gonidion **Physician** disease or condition resulting in death) /Medical Due to ( r as a consequence o Examiner Lunaku Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to (or as a consequence of Physician: The law requires that the death certificate be executed burial-transit Exami and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) the detached 9 TUnknown 9 Unknown ۾ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by After this certificate has been sign funeral director, page 2 should be apripho 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 □No 1 ☐ Yes 2 DaNo 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 1/16 1 Umpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending death, 2 Accident investigation 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one)

68760, Box o σ. Records, Division of Vital within 24 hours after deat To the Funeral Director:

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completely

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Mont

29b. Signature and title of certifier

MB Frattarola

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3001 Hospital DR Chevery, MD 20785

29c. License number

127628

29d. Date signed (Month, Day, Year)

09-25-2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Jennie Louise Jarvis ctober Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 216 Brookside <u>Terrace</u> Hagerstown Washington County If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1927Pennsylvania 1 M 2 XF Months Days Hours Min. 197-20-0869 83 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Washington County Hagerstown 1X Yes 2 ☐ No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 216 Brookstone Terrace 21742 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 1. Marital Status 14. Race - American Indian, Black, White, etc. Armed Force 1 ☐ Yes 2 ☐XNo If Yes, Give "natural", or þ 1 Never Married 2 X Married Maryland 21215-0036 1 Yes 2 XNo Specify. White Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Personal Residence and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Gesidio Sullo Nancy Unknown permit. Page 1 and 2 should Department of Health and Me Important: If item 27 is mar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James A. Jarvis-son 232 Mont Clair Ct. Hagerstown, MD 21742 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) 10-20-2010 Hershey, Pennsylvania Hershev Cemeterv 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee any i 1331 Eastern BLvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examir and -transit death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last physician a s the burial∹ Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Day Year ed by the a 1 ☐ Yes 2 ☐ Unknown 9 Unknown P.O. signed b Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No s certificate has lirector, page 2 2 🗌 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 4 No 1 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Morith, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of ertifier D0068 654 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

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DHMH 17 Rev 7/2009

MD

ed cause of death (Item 23a) (Type, Print)
THCP@HAGERSTOWN 12916 CONAMAR DR. STE 204

State of Maryland / Department of Health and Mental Hygiene []

Certificate of Death 2. Dete of Deeth 3. Time of Death **Physician** /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day 6. Sex lest birthdey) (State or Foreign Funeral Months Days Hours 1 M 2 TO F Yrs. Director Peges 1 end 2 should be filed within 72 hours eftar death with the Marylend 10a. Stete 10d. Inside City Limits items 23a or 28a-f show iner must be notified at 1 Yes 2 No Completed by Funeral Director 10f. Zip Code 10e. Street end Numbe 10g. Citizen of What Country? Race - American Indian, Black, White, etc. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 4 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 DNo Baltimore, Maryland 21215-0020 ŏ 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) el Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SCHOOL 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) la marked of 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Depertment of Health e important: If itam 27 la any injury or other trat 22070 KESTON, MD21655 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility WILLIAMSW F 311 S. MAINST 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical · renalfailure -Examiner Due to (or as a consequence of): e 2 months Physician/Medical Examiner mu Hiple myelomo for: After this certificata has been signed by the ettending physician and the funeral director, page 2 should be detached for use es the burial-transit Hospital or Attending Physician: The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 2 Be Completed 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Ves 25 IN: 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 □ Nursing Home 5 ☐ Mesidence 6 □ Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 1 (Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after deeth. Funeral Director: A 2 Accident investigation 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 To the F 29b. Signature and title of certifier 325 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) めら 136 Ledn 31. Date filed (Month, Day, Year) 32 Aegistrar's Signature State Registrar 1 9 2010

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				State of Maryland				-	•	
		•	For State Registrar	Otate of Marylana		tificate of Dea			eg. No. 2 1 1 1	34088
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Florence Louis	sa Mary N	loore			2. Date of Death October		3. Time of Death 4:12 Р. м
	Examin		4a. Facility Name (if not institution, give st Charlotte Hall Vet			4b. City, Town, or Loca Charlotte			4c. County of Death	
	Funeral Director		300-01-1341	M 2 🖫 F 7. Age (In yrs. last	birthday) Yrs.	If Under 1 Year 1f U Months Days Ho	nder 24 Hrs. urs Min.	8. Date of Birth May 9,	Year Co	hplace (State or Foreign intry) nesota
	ryland I-f show ied at	ctor	Usual Residence of Decedent  10a. State  10b. County	10c. City, 7						10d. Inside City Limits 1 ☐ Yes 2 🏋 No
	ith the Ma 3a or 28a t be notifi	Funeral Director	MD St. Mary  10e. Street and Number		arlot	te Hall		1	Og. Citizen of What Co	
36	2 should be filed within 72 hours after death with the Maryland this and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	by	1 Never Married 2 Married	Was Decedent Ever in U.S.     Armed Forces?     YY Yes 2 □ No	1	Vas Decedent of Hispani f Yes, specify Cuban, Me □ Yes 2 No Spe	c Origin? (Spec xican, Puerto F	cify Yes or No- Rican, etc.)	U.S.A.  14. Race - Amel Black, White Specify: wh	, etc.
Maryland 21215-0036	in 72 hours a e. nan "natural Medical Ex	Completed	3 X Widowed 4 □ Divorced  15. Decedent's Edu (Specify only highest grade)  Elementary/Seconday (0-12)	Year or Dates. 1943-4	16a. Deced	dent's Usual Occupation kind of work done during O NOT use retired)		ng I	   16b. Kind of Business     Anne Arunde	ndustry 21 County
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ryla	ould be d Menta marked matic e	To	Arthur Kruege  19a. Informant's Name/Relationship (Typ					Boelter		
e, Ma	and 2 sho Health an em 27 is ther trau		Doldon W. Moore, 20a. Method of Disposition	Jr., son	8321	Quince View	w Lane,	Owings	, MD 20736	5
Baltimore,	permit. Page 1 and 2 shu Department of Health an Important: If item 27 is any injury or other trau		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State cem	netery, cren	sition (Name of natory or other place) National	11/08	/2010	20c. Location - City or $rac{1}{2}$	VA
Bal	permit Depar Impor any in	Í	21. Signature of Funeral Service License	Tellach		Name and Address of F			•	P.A. 0736
1	Physician/		23a. Part 1. Enter the disease, or complishock, or hear fallure. List only one immediate Cause (Final disease or condition	cations that caused the death. I cause on each line.		er the mode of dying, suc		r respiratory arres	st,	Approximate Interval Between Onset and Death
لمر	Medical Examiner	r	resulting in death)  Sequentially list conditions,	Due to (or as a consequent	ice of):	LUTTER				
	be executed sician and burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	ESENT.  Due to (or as a consequent of the conseq	IAL	HYPE	RTEN	SION		
092		cal	C.	•						
. Box 6876	To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death.  within 24 hours after death.  completed filled in by the funeral director, page 2 should be detached for use as the temporal page.	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No   9   Unknown	3c. If yes, outcome of pregnance 1  Live Birth 2  Fetal d 4  Pregnant at time of dea 9  Unknown	eath 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
ds, P.O.	quires that t en signed b ould be deta		Part II. Other significant conditions con	DEFICIE			Part I.		acco use contribute to	the cause of death?
Division of Vital Records,	: The law recate has be ; page 2 sho	Completed by	OSTEOPOROS	IS				24a. Was an autops perform	prior to death?	opsy findings available completion of cause of
/ital	/sician s certifi director	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	ospital: 1	3/Outpatier	Other	Death (Check		nce 6 Other (Speci	
on of \	nding Phy ath. r: After this e funeral c		27. Manner of Death  1  Natural 5  Pending 2  Accident Investigation		Bb. Time of injury	28c. Injury at work?  M 1 □ Yes	2		w injury occurred	<u> </u>
Division	al or Atte s after des al Director ed in by th	I Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, stre	eet, factory, office		28f. Location (Str City or Town,	eet and Number or Rur State)	al Route Number,
	ne Hospit in 24 hour ne Funera pleted fill	Medical	(Check 2 L Medical Examine	cian: To the best of my knowled er: On the basis of examination a Practioner: To the best of my kn	nd/or invest	tigation, in my opinion, dea	ath occurred at	the time, date and	place, and due to the o	ause(s) and manner stated.
	Nith to to		29b. Signature and title of certifier	, MD		29c. License num			Od. Date signed (Month	
df	RW 12		30. Name and address of person who co	- n 1		erlotte Hali	1 P.4	Charlot	ta Hall M	20622
	Sta Registra			32. Registra's Signature				ondi 10L	re narre M	20022

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month JOHN DONALD October 11:10 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Memorial Hospital Frederick Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 🔀 M 2 🗆 F Days Hours Min March 31 Pennsylvania Yrs Director 207-28-4494 72 1938 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturo" any injury or other traumatic events. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🔀 Yes 2 🗌 No Frederick <u>Frederick</u> Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1001 Carroll Parkway Apt 320 21701 United States 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 X Married ☐ Yes 2 🛛 No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Specify Completed 3 Widowed 4 Divorced White Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Superintendant Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Edwin Moser Jessie Beatty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Apt. Mary J. Moser / Wife 1001 Carroll Parkway, Frederick, Maryland 21701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🗵 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory Inc. 10/12/10 Frederick, Maryland 21. Signatur 1 Funeral Service Licenses \$22. Name and Address of Facility Stauffer Funeral 1621 Opossumtown Home P. A. Pike, Frederick, Maryland 21702 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Neumania disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown 2 🔲 No cate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performe 1 Yes 2 No Yes 2 XNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital Other: မ 1 🔲 Yes 1 Sinpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No Accident Investigation Director Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day. Year) VND 51610 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Fre

Registrar's Signature

Iane

31. Date filed (Month, Day

21702

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34090 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 8:58 A<sub>M</sub> October Physician/ 201 Deanita May Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 10904 Waco Drive Prince George's Upper Marlboro Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 9. Birthplace (State or Foreign Country) DC **Funeral** Days 1 □ M 2 🔀 F Director 578 70 3333 58 Usual Residence of Decedent show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 X Yes 2 No MD Prince George's Upper Marlboro 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 20772 Funeral 10904 Waco Drive USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Force Black, White, etc. þ 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 K Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black "natural", Completed 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Analyst 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Unknown Juanita High of Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katina J. Garner/Daughter 10904 Waco Drive Upper Marlboro, MD 20772 Page 1 and 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o ó 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Heritage Cemetery Oct.19 Waldorf, MD Signature of Funeral Service Lig 22. Name and Address of Facility Briscoe-Tonic Funeral Home 2294 Old Washington Rd. Waldorf,MD 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) Navian Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) or Attending Physician; The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate has autopsy 1 Yes 2 🗌 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 X Natural injury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) October 15,2010

aB

State Registrar 30. Name and address of person who co

OCT

1 8 2010

NWAEHI'H

6201 Greenbelt Ru. College Park, 20740

Greenbelt Rd.Suite U3

d cause of death (Item 23a) (Type, Print)

Registrar's Signature

	State of Maryland / Department of Health and Mental Hygiene  1 - State Registrar  Certificate of Death  Reg. No. 2 0 1 0 3 4 0 9											
			Registrar	.4)	Cel	TITICATE OF L						
	Physicia	n/	Decedent's Name (First, Middle, Las	•	W4 4 4 1 a	+		2. Date of Dea Month		3. Time of Death		
	Medic			nnette Clarke	мтаате			0ctobe				
	Examin	er	4a. Facility Name (if not institution, give	· ·			Location of Death	1	4c. County of Dea			
	Funeral		10025 E11ard Dr 5. Social Security Number 6. Se		last hirthday)	Lanh	If Under 24 Hrs.	8. Date of Birt	Prince	irthplace (State or Foreign		
	Director			□ M 2 <b>X</b> F 84	Yrs.	Months Days	Hours Min.			shington, D.C.		
			Usual Residence of Decedent					T O GARO -	, 1910   111			
	land f sho	ţ	10a. State 10b. County	10c. Cit	ty, Town or Lo	cation				10d. Inside City Limits		
	Mary 28a-i otifie	irec	Maryland Prince	Georges I	Lanham					1 X Yes 2 ☐ No		
	e filed within 72 hours after death with the Maryland thal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	•		
	th wit	iner	10025 E11ard Dr			2070			United St	ates		
	r dea		11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S Armed Forces?		Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puert	pecify Yes or No- po Rican, etc.)	14. Race - Am Black, Whi			
38	al", o	d by	3 X Widowed 4 Divorced	1 ☐ Yes 2 <b>X</b> No If Yes, Give		Yes 2X No	Specify:			Black		
ŏ	hours vatur	Completed	15. Decedent's Ed	Year or Dates.	16a. Deced	ient's Usual Occup	ation		16b. Kind of Business	e Industry		
715	n 72   an "r Med	E G	(Specify only highest gra	ade completed) College (1-4 or 5+)	(Give I	kind of work done o O NOT use retired)		king	George Wa	,		
21	within giene er th	ပိ	10th grade	College (1-4 or 5+)	Nur	sing Ass	istant		_	y Hospital		
pu	filed al Hy d oth	) Be	17. Father's Name (First, Middle, Last)	_					Maiden Surname)			
Baltimore, Maryland 21215-0036	age 1 and 2 should be fill on of Health and Mental to If Item 27 is marked of or other traumatic ever	욘	Theodore Da	vis			Cathe	rine T	homas			
Nar	shou raum		19a. Informant's Name/Relationship (T)			-			; City or Town, State, Z	• *		
ď	and 2 Health		Goldie Johnetta  20a. Method of Disposition		<del></del>		Drive;L	anham, M				
آور	Page 1 nent of I ant: If it		1 Burial 2 X Cremation 3 D	Removal from State	emetery, cren	sition (Name of natory or other plac	e) Oct.	20,2010	20c. Location - City of	or Town, State		
垂	E E E		4 ☐ Donation 5 ☐ Other (Specif			ke_Cremat			Beltsville			
Ba	permit. Departr Importa any inju	1	21 Signature of Funeral Service Livens	de R. M. A.						Morticians,		
			23a. Part 1. Enter the disease, or comp	elications that sourced the death						ton,D.C.20011		
			shock, or heart failure. List only of Immediate Cause (Final	ne cause on each line.		a the mode of dylin	y, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death		
	Physician/ Medical		disease or condition resulting in death)	a. Uterine Ca						Office and Death		
	Examiner			Due to (or as a consequ	uence or):							
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	d ansit	ami	cause. Enter Underlying Cause Unsease or impury that initiated events	^								
	exect an an rial-tr	EX	resulting in death) Last	Due to (or as a consequ	uence of):							
09	ate be executed physician and the burial-transit	dical Examiner		d								
87	tifica ing pl	Me	IF FEMALE:						T			
Box 687	eath certifica attending p	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 Live Birth 2 Feta	aldeath 3 🗌	Ectopic pregnanc	у		23d. Date of d	*		
B	e dea the a	ysic	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	4 ☐ Pregnant at time of o	death 5∟	Other (specify)			Month	Day Year		
P.O.	iires that the dea signed by the a id be detached f	by Physician/Me	Part II. Other significant conditions co	ontributing to death but not res	sulting in the u	nderlying cause giv	en in Part I.	23e Did to	bacco use contribute t	o the cause of death?		
S, F	signe d be	d b								Probably 4 🗆 Unknown		
ord	v require s been si should	lete						24a. Was a		utopsy findings available		
ပိုင	e law e has ge 2 a	Completed						autop	sy prior to	completion of cause of		
<u>m</u>	sician: The certificate rector, pag		25. Was case referred to medical			20. D.	( D	perfor	2 <b>X</b> No 1 □ Ye	es 2 No		
lita	sicia certi irecto	o Be	examiner?	Hospital:	ED 10	160	ace of Death (Chec					
=	Physeral di	은:	27. Manner of Death	1  Inpatient 2  28a. Date of injury	28b. Time of	t 3 🗆 DOA   28c. Injury			ence 6 Other (Spe	cify)		
Division of Vital Records,	nding ath.	icat	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day, Year)	injury	work'			on many cocomica			
<u>isi</u>	l or Attending after death. Director: After In by the funer	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho		et, factory, office			treet and Number or R	ural Route Number,		
<u>S</u>	tal or rs aft al Dir ed in			building, etc. (Specify	"			City or Tow	n, State)			
	Hospital 24 hours Funeral sted filled	Medical	29a. Certifier 1 Certifying Phys (Check 2 Medical Exami	sician: To the best of my knowl ner: On the basis of examination	ledge, death o	occured at the time,	date and place, a	nd due to the cau	ise(s) and manner as si	tated.		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Me	only one) 3 L Certifying Nurs	e Practioner: To the best of my	y knowledge, c	leath occurred at the	time, date and pla	ce, and due to the	cause(s) and manner a	s stated.		
	<b>5</b> 5 € 5		29b. Signature and title of certifier	^		29c. License			29d. Date signed (Mon			
			- DENGUSZ	-00		Н666			October /	<b>5</b> , 2010		
2	1		30. Name and address of person who c		ı 23a) (Type, P			-				
	Stat	P	Dona Leskusk 31. Date filed (Month, Day, Year)	32, Registrar's Signat	ture	Largo,	Marylan	d 20774				
	Registra		OCT 1 8 2010 A	news B. Ala	wes							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 16 20ÎÖ Beatrice Mae Minamoto 7:45 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Talbot Easton William Hill Manor Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** <sup>Year</sup> 1933 Days 1 M 2 TYF Hours  $J_{\mathbf{u}}^{(Month, Day)}$ Director Massachusetts 154-24-5070 Usual Residence of Decedent or 28a-f show filed within 72 hours after death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Caroline Denton 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21629 U.S.A. 10169 River Landing Road 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. \$ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Yes 2 No Specify If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced Specify: White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Manager Food Service Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important; If item 27 is marked oth any injury or other traumatic even 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nathan French Vergie Grace Rowan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ben Minamoto/spouse 10169 River Landing Road, Denton, Maryland 21629 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Denton Cemetery Oct. 21, 2010 | Denton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licer 22. Name and Address of Facility Moore Funeral Home, P.A. aude 12 South Second Street, Denton, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Priysician to Failure disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Examine the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ♣ No
9 ☐ Unknown 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 출 1 Yes 2 No 3 Probably 4 Unknown Completed Leuko ey tosis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed nertension 1 ☐ Yes 2 ☐ No Yes Be ( 25. Was cas- r- erred to medical examiner? 26. Place of Death (Check only one) Other: 4 | Nursing Home 5 | Residence 6 Other (Specify) Asst. Living 1 ☐ Yes 2 🕱 No Hospital: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Matural work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has to the Funeral Director, After thineral director, page 2 s

R077623 10-18-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 545 Cynwood Dr. Thomas Krystal 31. Date filed (Month, Day, Year) 2. Registrar's Signature State

Registrar

Medical

29a. Certifier

only one

29b. Signature and title of certifier

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Medical Examiner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Betty Lou Mitchell State of Maryland / Department of Health and Mental Hygiene 2010 Certificate of Death 10/19/10 AJS CCHIDNO Amended #9 per fh Registrar Physician/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day October 15, 2010 Medical Examiner 1815 hrs Betty Lou Mitchell

4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Whitleysburg Road West of Whites Lane Greensboro Caroline 8. Date of Birth (MM/DD/YYYY) 9. Sirthplace State are 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Director Months Davs Hours Min Country) 1 M 2 X F 216-64-8925 56 May 31 Vialey Gine Usual Residence of Decedent 10b. Count 10c. City, Town or Location 10d, Inside City Limits s 23a or 28a-f show e notified at once, 1 Yes 2 No Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygone.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho ant: Yor other traumatic event, the Medical Examiner must be notified at once. Delaware Kent rector Felton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 153 Sandalwood Drive 19943 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 8lack, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 XNever Married 2 White, etc. Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: White ⋧ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 12 Shipping and Receiving Manufactoring 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) <u>Wilmer Mitchel</u> <u> Mariorie Ann Hanlev Mitchell</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wilmer Mitchell 14236 Drapers Mill Road Greensboro, MD 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 1 Burial 2 Cremation 3 Removal from State crematory or other place) Important: injury or oth 10/21/10 4 Donation 5 Other Specify. Greensboro Cemetary Greensboro, MD 21 Signature of Funeral Service License permit. 22. Name and Address of Facility 106 W. Sunset Ave. Greensboro, MD 21639 23a. Part I. Enter the disease, op complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line. Between Onset and Medical Death a Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical attending physician a UNPENDED AMENDED Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy Dav past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown ned by the a P. 0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed b <u>۾</u> 1 Yes 2 V No 3 Probably 4 Unknown Completed Division of Vital Records, 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has 2 si death? performed s certificate h rector, page 2 Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other<sub>4</sub> this Nursing Home 5 Residence 6 ✔ Other: Scene ၉ 1 🗸 Yes After th 28a. Date of Injury (Month, Day Year) Oct 15, 2010 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? Certification: Driver of car lost control, struck a ditch and within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Natural 1746 hrs 5 Pending 1 Yes 2 V No ejected 2 V Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) Whitleysburg Road West of Whites Lane, Greensboro, (Specify) Major Road Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated, Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 16, 2010 30. Name and address of person who completed cause of death (tem 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month Pay Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Physician/ 10 DOMINIC Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** g. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under Funeral Hours Min 1 🔀 M 2 🗆 F 0'2'9'2'79'1'949 Maryland 213-54-5827 61 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a, State death with the Maryland Director MD Crownsville 1 ☐ Yes 2 ី No Anne Arundel 10e. Street and Number 10g. Citizen of What Country? Funeral 1069 Plum Creek Drive 21032 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 XXNo Black, White, etc. þ 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: White 3 Divorced 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Foreman 15. Decedent's Education 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important. If item 27 is marked other than "na any injury or other traumatic event, the Maximone. (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dominick Thomas Morrone Juanita Clarke 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Peggy Sue Morrone 1069 Plum Creek Drive Crownsville, MD 21032 Spouse 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory or other place 10/16/2010 Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 851 Annapolis Road Gambrills, MD 21054 Dals Hardesty Funeral Home P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of): Physician/ disease or condition Medical resulting in death) Examiner + SARATOR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IE FEMALE: 23c. If yes, outcome of pregnancy
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1 □ Yes 2 □ No 24a Was an autopsy performed has page certificate 2 No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA 욘 ours after death.

neral Director: After this of filled in by the funeral dir 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a

To the Funeral D

completed filled i Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S+ Baltimory my ZIZOI DAWOOD

DHMH 17 Rev 7/2009

Registrar

MURTAZ 31. Date filed (Month, Day, Year,

OCT 1 4 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Month 0/12/2010 Physician/ 7:00 Thomas D. Neis, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Friendship 6517 Wilson Road Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth Birthplace (State or Foreign Country)
 MAN 7. Age (In yrs. last birthday) **Funeral** Months Month Day 7 1931 1 X M 2 - F 78 **Director** 475-30-3635 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location 72 hours after death with the Maryland Director 1 🗆 Yes 2 🖾 No Friendship Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20758 6517 Wilson Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. ð 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: "natural" Completed 3 Widowed 4 Divorced White the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Administration Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alvina Dominik ၉ Peter Neis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 733 Larve Road, Millersville, MD 21108 Kathryn Bury / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State any injury or 10/19/2010 Maryland Veterans Cem. Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Falleral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. J. Golf 8125 Southern Maryland Blvd., Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between set and Death Immediate Cause (Final Is chemic My occordiopathy Physician/ disease or condition resulting in death) Medical Examiner Chronic Obstructive Pulmonary Disease/ Vecur Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Means Chronic Hypoxemia Exami Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last toselerate Cardiovascular Diceans emy Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death 5 Other (specify) ed by the a detached f g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dreusa 2 No 3 Probably 4 Wunknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perforn 1 Yes 2 No certificate Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 PResidence 6 Other (Specify) Hospital: 1 Tes 2 7 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dii 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5  $\square$  Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D17245 october 12, 2010

JRW 10

Registrar
DHMH 17 Rev 7/2009

MD, 19 Chesapeake Beach Road, East, Owings, MD 20736

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Gerald P. Sterner,

OCT

31. Date filed (Month, Day, Year)

			1 - For Amend Item 2 Registrar	5 per me,	gyland 1/10ep Ce	artment of 72010ah rtificate of	Health an Death	d Mental Hy	giene Reg. Ng2 ()   ()	34096	
Physician /Medical			1. Decedent's Name (First, Middle, Last)			Phelps			2. Date of Death Month Cotoler 12 2610		
M	Examir		4a. Facility Name (If not institution, give The Johns Hopkins Ho	spital		Baltimor			4c. County of Dea		
	Funeral Director		5. Social Security Number 6. Se 1 Security Number 6. Se 1 Security Number 6. Security Number 1 Securit	x 7. Age ☐ M 2 🖾 F	e (In yrs. last birthday)	If Under 1 Yea Months Days		Min. 8. Date of Bird (Month, Da Oct. 24	ry, Year) Co	rthplace (State or Foreign buntry) SSISSIPPI	
	a-f show	ctor	10a. State 10b. County  Maryland Howard	-	10c. City, Town or L					10d. Inside City Limits 1 ☐ Yes 2 ื No	
4	with the	Director	10e. Street and Number			10f. Zip-Code			10g. Citizen of What C		
36	uges I and a should be lied within 7.2 hours aret death with the maryland that and Mental Hygiene. If item 271s marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	2521 Daisy Road  11. Marital Status  1 □ Never Married 2 ⊠ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1  Yes 2 X			ban, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)	Black, Whi	erican Indian, te, etc.	
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d 21	Hygiene.		17. Father's Name (First, Middle, Last)	4		Homemake	_	Name (First, Middle	Own Home, Maiden Surname)	ie	
Maryland	Mental Mental arked c	To Be	Russell C. Arnold				_	Sulfridge			
	Ith and Meni		19a. Informant's Name/Relationship (T)  James G. Phelps/			,			per, Cify or Town, State, aryland 217		
_ (	rages I and a not of Health Int: If item 27 I		20a. Method of Disposition  1 🔀 Burial 2 🗆 Cremation 3 🗀 4 🗀 Donation 5 🗀 Other (Specify,	Removal from State	20b. Place of Disp cemetery, cre	osition (Name of matory or other pl	ace)	Date	20c. Location - City o		
Baltir	pernin, rages rand a Department of Health a Important: If item 27 li any Injury or other tra once.		21. Signature of Furieral Service Licens		S	2. Name and Add	ress of Facility Funeral	Homes P.			
	hysician		23a. Part r. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	ications that caused ne cause on each line	the death. Do not en	1 3.	growing, such as ca		arrest,	Approximate Interval Between Onset and Death	
	Medical xaminer		resulting in death)	a consequence of):	nce of):			1			
100	d	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	a consequence of):			TON APPROVED BY ME	OKAL EXAMINER		
8760,	hysician and the burial-transit	edical Ex	resulting in death) Last	Due to (or as a	a consequence of):		o.K	TION APPROVED BY ME			
687	ng phys		IF FEMALE:	u	-		CERTIFICA	i i			
I Records, P.O. Box 68	within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	23c. If yes, outcome of the line of the l	2 Fetal death 3	Ectopic pregnar Other (specify)	ncy		23d. Date of de Month	elivery Day Year	
rds, P.	signed by	by	Part II. Other significant conditions co	ntributing to death be	ut not resulting in the	underlying cause	given in Part I.	23e. Did t	tobacco use contribute Yes 2 No 3 🗆 F	to the cause of death?	
	ate has bee page 2 sho	Completed						24a. Was autop perfo	osy prior to ormed? death?	utopsy findings available completion of cause of s 2 \( \subsection \) No	
r Vita	certific	To Be	25. Was case referred to medical examiner?  1 X Yes 2 ANs	Hospital: 1. Inpatie	nt 2 ER/Outpatie	nt 3 DOA	26. Place of ther: 4 \( \subseteq \text{ Nursir} \)	Death (Check only only only only only only only only		ecify)	
	th. After this funeral		27. Manner of Death  1 Natural 5 Pending investigation	28a. Date of Injur (Month, Day		We	ury at ork? Yes 2No	28d. Describe I	how injury occurred		
Divis	within 24 hours after death.  To the Funeral Director: After this certified completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be determined	28e. Place of inju building, etc		t, farm, street, factory, office  28f. Location (Street and Number or Rural Roc City or Town, State)					
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To #	within 2  To the comple	Me	29b. Signature and title of certifier			_	se number		29d. Date signed (Mon	th, Day, Year)	
	4		30. Name and address of person who o	ompleted cause of d	eath (Item 23a) (Type				UE CL D-III	are MD cross	
	Sta		31. Date filed (Month, Day, Year)	32. Registra	s Signature	/ .	, 60	JU NORTH WO	one St, Baitim	ore, MD, 21287	
	Registr	ar	11111 1 4	/UH - /2.	asers a M	BRIKE	7				

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3   Suicide 4   Homicide   28e. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural. City or Town, State)   29a. Certifier (Check only one)   29a. Certifier (Check only one)   29b. Signature and title of certifier   29b. Signature and title of certifier   29c. License number   29d. Date signed (Month, Date of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural. City or Town, State)   29b. Signature and title of certifier   29c. License number   29d. Date signed (Month, Date of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural. City or Town, State)   29b. Signature and title of certifier   29c. License number   29d. Date signed (Month, Date of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural. City or Town, State)   29b. Signature and title of certifier   29c. License number   29d. Date signed (Month, Date of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural. City or Town, State)   29b. Signature and title of certifier   29c. License number   29d. Date signed (Month, Date of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural. City or Town, State)   29b. Signature and title of certifier   29c. License number   29d. Date signed (Month, Date of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural. City or Town, State)   28f. Location (Street and Number or Rural. City or Town, State)   28f. Location (Street and Number or Rural. City or Town, State)   28f. Location (Street and Number or Rural. City or Town, State)   28f. Location (Street and Number or Rural. City or Town, State)   28f. Location (Street and Number or Rural. City or Town, State)   28f. Location (Street and Number or Rural. City or Town, State)   28f. Location (State)	on of V ding Physic th. After this ce funeral dire	1 ☐ Yes 2 Alo	28a. Dete of Injury	28b. Time of Injury	28c. Injury at Work?				spice 1103
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Date of December 2)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Divisi bal or Atten al Director led in by the	3 Suicide 6 Could not be 4 Homicide determined	200. Flace of Injuly - At III		ry, office			er or Rural Route	a Number,
29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, D  29d. Date signed (Month, D  30. Name and address of berson who completed cause of death (Item 23a) (Type, Print)	he Hospl in 24 hou he Funer pletely fil	29a. Certifier 1 A Sertifying Phy (Check only 2 Medical Exem	iner: On the basis of examina	tion and/or investigation	n, in my opinion, death occ	urred at the time, d	late and place, a	and due to the ca	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Tot with To to com	> mffeet	len ms				_		
State 31. Date filed (Month Day Year) a 2010 32. Degistrar's Signatures back		Michael FAC			Ave Heri	lock 1	nd 21	643	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Ĩ8 20Î0 **Physician** 8:45A M October Reiland Frederick George /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Caroline Denton Envoy of Denton If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Days Min. 78 PΑ 203-24-1967 17/1932 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Heatth and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State ns 23a or 28a-f shor 1 □XYes 2 □ No Denton MD Caroline 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 言 United States 21629 420 Colonial Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 ☐ No 14. Race - American Indian, Black, White, etc. 7 is marked other than "natural", or items traumatic event, the Medical Examination Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1X Yes 2 No
If Yes, Give
Year or Dates: 52-55 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White 2 3 ☐ Widowed 4 K Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Trucking Compau 12 Loading 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edna BH Bender 2 Frank Railand 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) sister -in 142 Victor Cabbage Rd+ Hohenwald, TN 38462 Jean Darnell Selfinger/<sub>law</sub> 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 to Department of Important: If it any injury or conce. 1 → Burial 2 □ Cremation 3 □ Removal from State MD Veterans Cemetery 10/22/2010 Hurlock, Maryland 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licensee 22. Name and Address of Facility Foloece Framptom Funeral Home, Federalsburg, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DAVS Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 ☐ Other (specify) been signed by the should be detached I □ Yes 2 □ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy certificate ! 1 ☐ Yes 1 TYes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4™ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No ours after death.

neral Director: / 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10-18-2010 D0053094 INBULD 321 BLOOMING DALE AVE FEDERALSBURG, MD

State Registrar

DHMH 17 Rev 1/2001

152×

10-07730 Robert Rockinghar		Please Type or Print in Black Indelible Ink. Ensure Richardson State of Maryland / Department of Health and 1- For State Certificate of Death		/giene	201	0 34099
Physician	_	Registrar  1. Decedent's Name (First, Middle,Last)		2. Date of Death	j. No.	3. Time of Death
Medical Examine		Robert Rockingham Richardson		Month October 8,		0553 hrs
		4a. Facility Name (if not institution, give street and number)  3956 Federalsburg Highway  4b. City, Town, or Federalsburg			4c. County of Dea	
Funeral Director	Ĺ	5. Social Security Number 220-32-1020 1 Months 2 F 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 9. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 9. Age (In		8. Date of Birth Feb. 18	(MM/DD/YYYY) 9. E 3, 1932	Birthplace (State or eign CountryMichigan
nd show any ice.	r	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location Feder  MD Caroline Feder	alsburg			10d. Inside City Limits  1 Yes 2 X No
th the Maryland 23a or 28a-f show notified at once.		10e. Street and Number 4789 Howard Road	21632	100	g. Citizen of What Co United	
er death with , or items 23 r must be no		11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No	n, Mexican, Puerto		14. Race - Am White, etc.	
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once To Re Completed by Finneral Director	inpleted by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12  College (1-4 or 5+)  Crain & Poul	tion (Give kind of w DO NOT use retir	red)	16b. Kind of Busines Agricul Poul	ture/
215-0036 be filed within 7 mtal Hygiene. rked other than ent, the Medica		17. Father's Name (First, Middle, Last) Arthur R. Richardson	18.Mother's Name Winifr		aiden Surname)	
MD 21. 2 should ? h and Mer 27 is mar martic ev		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Stree Elizabeth Richardson/Wife 4789 Howard				
more, R Pages I and nent of Healt nut: If item	- 1	20a. Method of Disposition  1			20c. Location - City Federal	
Balti permit. Departm Imports injury	ŀ	21. Signature of Funeral Service Licensee 22. Name and Address 216 N. Main	n St., Fe	ederalsb	urg, MD 2	1632
Physician /Medical xaminer		Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, failure. List only one cause on each line.     Immediate Cause (Final disease a Multiple Injuries	, such as cardiac o	r respiratory arres	st, shock, or heart	Approximate Interval Between Onset and Death
		or condition resulting in death)  Due to (or as a consequence of):				
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unsease of highly that initiated				
	Z	events resulting in death) Last  Due to (or as a consequence of):  d.				
be executed ician and unial - transi	2 -	UNPENDED AMENDED				
ords, P.O. Box 68760, we requires that the death certificate be executed as been signed by the attending physician and should be detached for use as the burial - transitional by the burial - transitional burief or the stansitional burief or the stansition of the stansition	I y SI CI AI I MIC	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 4 Pregnant at time of 5 Other (Specify) 1 Unknown	Ectopic pregna		23d. Date of deliv Month	Day Year
P.C es that gened to be deta	3	Part II. Other significant conditions contributing to death but not resulting in the underlying cause of	given in Part I.			to the cause of death?  Probably 4 Unknown
ords, aw require as been si	biered			24a. Was a autops	sy prior	autopsy findings available to completion of cause of

Division of Vital Recorr To the Hospital or Attending Physician: The law 17 within 24 hours after death. To the Funeral Director: After this certificate has be completely filled in by the funeral director, page 2 sho

Medical Certific

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the funeral director, page 2 should be detached for use as the burial -	ation: To Be Completed by Physician/Medic
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1 Yes 2 No 9 Unknown	Pregnant at time of 5 Other (	Specify)				
Part II. Other significant conditions co	ntributing to death but not resulting in the under	ying cause given in Part I.		co use contribute to the cause of death?  No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  No 1 Yes 2 No		
25. Was case referred to medical examiner?  1  Yes 2 No	oital: 1 Inpatient 2 ER/Outpatient 3	26 Place of Death (Check		idence 6 ✔ Other: Scene		
27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury Oct 8, 2010 28b. Time of Injury 0550 hrs	28c. Injury at Work? 1 Yes 2 ✓ No	28d. Describe how Pedestrian stru			
2  Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, faction (Specify) Major Road / Highway	ctory, office building, etc.	28f. Location (Street and Number or Rural Route Number, Cit or Town, State) 3956 Federalsburg Highway, Federalsburg, MD			
one) 2 Medical Examiner:On	To the best of my knowledge, death occurred a n the basis of examination and/or investigation, i d manner stated.	n my opinion, death occurred	at the time, date and	place, and due to the cause(s)		
29b. Signature and title of certifier		29c. License number	29	d. Date signed (Month, Day, Year)		

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

State 31. Date filed Month Day, year 2010 Registrar

29b. Signature and title of certifier

Pamela E. Southall, MD

Panal Futhull, MD

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

2. Registrar's Signature

October 9, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 0 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 2010 Eileen Mae Speorl Oct. 14 8:00 a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Calvert Huntingtown Caribbean Breeze 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months 127207 4918 Director MD 577-09-5712 91 Usual Residence of Decedent show 10a. State 10b. County "natural", or items 23a or 28a-f sho 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Calvert St. Leonard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7401 Bond St. 20685 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Force Black, White, etc. ğ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: 3 X Widowed 4 □ Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 1 and 2 should be filed with of Health and Mental Hygien item 27 is marked other th other traumatic event, the 11 <u>Cosmetologist</u> Retail Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည William Brown Myrtle McKnew 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Johnson/Son 7401 Bond St., St. Leonard, MD 20685 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of I Important: If it any injury or of once. Ę. cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Loudon Park Cem. 10/19/10 Baltimore, MD 22. Name and Address of Facility Raymond-Wood F.H., P.A. 21. Signature of Funeral Service Lidensee Dunkirk, MD 20754 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner if any leading to immedia cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and -tran Due to (or as a consequence of): resulting in death) Last burialattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown ☐ Pregnant at time of death ☐ Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy this certificate 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, ASSIST 60 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 hours after death.

uneral Director: After this
ed filled in by the funeral di 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Could not be Accident 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 62090 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JRW STANCLY WSKI MA 31. Date filed (Month, Day, 32. Registra State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month October 11, 2010 **Physician** Lawrence Evander Spriggs 7:00 a M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Calvert Memorial Hospital Prince Frederick Calvert 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 12 M 2□ F Hours Months Days Director 212-30-8634 February 28, 1933 MD Usual Residence of Decedent show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Nedical Examiner must be notified at Director 1 ☐ Yes 2 ☑ Ño MD Calvert Dunkirk 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 550 W. McKendree Road 20754 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐Yes 2 ☑No If Yes, Give Year or Dates: Specify: ⋧ Specify 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 7 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Motor Vehicle Operator Government alth and Mental Hv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James E. Spriggs Mary Tasker ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau Shirley M Spriggs - wife 550 W. McKendree Road, Dunkirk, MD 20754 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Spriggs Cemetery October 16, 2010 Dunkirk, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sewell Funeral Home, P.A. 21. Signature of Funeral Service-Licensee 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute **Physician** Mupcardia disease or condition resulting in death) hour /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if a y, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) O. Box 68760. attending physician for use as the burial Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown signed by t σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a Was an cate has page 2 s autopsy performed? Yes 2 12 No certificate 1 ☐ Yes of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 № No ပု 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 🔀 DOA this After thi funeral of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Medical Certification: 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural r death. 1 ☐ Yes 2 ☐ No nours after death neral Director: , y filled in by the f 2 Accident 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🖼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. . 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 38563 uspeum 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jew) Ra , West River O Wens ville respand ayne 31. Date filed (Month, Day, 32. Registra s Signature Year) State Registrar

10-07715 Christopher Schoenfeldt Plea

ase Type or Print in Black Indelible Ink	<ul> <li>Ensure All Copies Are Legib</li> </ul>	lennin	21.102
State of Maryland / Department of F	lealth and Mental Hygiene	2010	34102

	1- For State Registrar		Certifica	ate of I	Death			Reg	. No.		
Physician/	Decedent's Name (First, Middle)	e,Last)					2. Date Mon	of Death	Day Yea	3. Time of Death	
Medical Examiner	omrageopher	Scott	Schoen				Oct	ober 7, 2	2010	1703 hrs	
	4a. Facility Name (if not institution 1105 Old Eastern Ave			45	City, Town, or L Essex	Location of	Death		4c. County of Baltimor	or Death re County	
Funeral	5. Social Security Number	6. Sex 7. Ag	e (In yrs. last birt	hday)	If Under 1 Year			te of Birth	(MM/DD/YYYY	9. Birthplace (State or Foreign	
Director	217-68-9754	1XM 2F	40_	Yrs.	Months Days	Hours	Min. O	4/10/	1970	Washington,	DC
riy	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location	1					10d. Inside City L	imits
Maryland 28a-f show any d at once. ector	MD Anne	Arundel	Lothi	an						1 Yes 2	No
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2121 ould be fill Mental I marked ic event,	19a, Informant's Name/Relations		choenfel	o. Mailing /	Address (Street	and Numb	oyce er or Rural Ro	An oute Numb	er, City or Tow	Hardesty vn, State, Zip Code)	
AD 2 short hand hand marking image	Joyce H. Schoen	nfeldt. moth	er 6	031 E	isher S	tatio	n Road	, Lot	hian, l	MD 20711	
Te, Te, I and I and Healt Healt fitem	20a. Method of Disposition  1 Burial 2 Y Cremation		20b. Place of	of Dispositi	on (Name of cem	netery,	Date		20c. Location -	- City or Town, State	
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Baltimore, MD oemit. Pages I and 2 shc Department of Health and Important: If item 27 is injury or other traumati	21. Signature of Funeral Service	Licensee								ome, P.A.	
	23a. Part I. Enter the disease, or	g subjections that caused		832 of enter the	.5 Mt. Ha	armon	y Lane	. Owi	ngs. M	D 20736 art Approximate Int	erval
Physician / /Medical	failure. List only one cause	on each like.								Between Onset	and
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760 icate by the pu	IF FEMALE: 23b, Was decedent pregnant in the	23c. If yes, outco	ne of pregnancy		I death 3				23d, Date of Month		
30x 687 death certifing e attending for use as t	past 12 months?	I FIAG DILILI	time of death	=	rdeath ⇒ ∐ er(Specify)	Ectobic b	pregnancy		WOTH	Day real	
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Division of spiral or Attending Jours after death. neral Director: After filled in by the function. Certification:	3 Suicide 6 Coul	d not be 28e. Place of Ir	njury - At home, fa		factory, office bu	uilding, etc.	28f. Lo	cation (Str Town, Sta	eet and Numb	er or Rural Route Number, Old Eastern e, MD	City AV
Di Hospital 24 hours a Funeral rely filled	4 Homicide dete		esidence								
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial -transi ledical Certification: To Be Completed by Physician/Medical Ex	(Check only 1 Certifying P. one) 2 Medical Exa	hysician: To the best of m	iy knowledge, de: mination and/or i	ath occurre nvestigatio	n, in my opinion,	te and place death occu	e, and due to urred at the tin	ne, date ar	s) and manner nd place, and c	r as stated. due to the cause(s)	
or con	29b. Signature and title of certific	and manner stated			29c. License	number			29d. Date sign	ned (Month, Day, Year)	
	11/1/6	2/	11)		O.C.N	И.E.			October 8,	2010	
1000 2	30. Name and address of person Russell Alexander MD	111		111 0	Penn Street,	Baltimor	e. MD 212	01			
State	31. Date filed (Month Day Year)	32. Registra	ar's Signature	- 111				-			
Registra	11111		un B.	Spar	Kal			0014	r		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Amended #16a per FH, RG FCHD 10/14/10 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 Year Carolyn E. Sawczyn October Medical :55 P 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Edenton Retirement Frederick If Under 1 Year | If Under 24 Hrs. Funeral Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Gountry) MA Days (Month, Day Youly 17, 1 M 2 F Months Hours Min Director Yrs 1932 July 018-24-9019 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No Frederick MD Frederick 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21703 5901 Genesis Lane Apt. BP222 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Mamed ☐ Yes 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 houn Department of Health and Mental Hygene.
Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Nurse Registered Nurse Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ John Chester Kean Teresa Whitney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Sawczyn 112 Graylyn Drive, Chapel Hill, NC 27516 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) Stauffer Crematory 10/14/2010 Frederick, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause an each line. Approximate nterval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) year Medical Due to (or as a consequence of): Examiner VOUNIC ears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown Pregnant at time of death Month signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No this certificate 1 Yes 2 No To the Hospital or Attending Physician: "
within 24 hours after death.
To the Funeral Director: After this certifics completed filled in by the funeral director, to Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 🔀 Nursing Home 5 🗌 Residence 6 🗍 Other (Specify) 1 Yes 2 X No ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 1 Tyes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier. 29d. Date signed (Month, Day, Year) m 10-12-2010 en 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

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32. Registrar's Signature

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31. Date filed (Month, Day, Year)

tezou Frederick Md

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Fred Cecil Smith October 10, 2010 6:40 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick 8535 Apples Church Road Thurmont If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye April 30, Social Security Number 7. Age (In yrs. last birthday, g. Birthplace (State or Foreign **Funeral** Hours Min. 1 X M 2 □ F , 1<u>930</u> 80 Virginia Director 213-24-9533 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at. permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Frederick Thurmont 10e. Street and Number 10g. Citizen of What Country? Funeral 8535 Apples Church Road 21788 United States 12. Was Decedent Ever in U.S.
Armed Forces?
1 

Yes 2 □ No
1f Yes, Give Korean
Year or Dates. War Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, <u></u> 1 Never Married 2 M Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Carpenter/Contractor Self-Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Thomas Smith Artie May Killen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris A. Smith / Wife 8535 Apples Church Rd., Thurmont, MD 21788 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State October 15 1 🖾 Burial 2 🗀 Cremation 3 🗀 Removal from State Forest Oak Cemetery 2010 4 ☐ Donation 5 ☐ Other (Specify) Gaothersburg, Maryland 21. Signature of Fundal Service Licensee REStravendentifical Services, Skkot Cody P.A. M 01237 Frederick, MD 21701 9501 Catoctin Mountain Hwy. 23a. Part 1. Enter the disease, or of shock, or heart failure. List on inplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between nset and Death Months Immediate Cause (Pinal Physician, Lun Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examine Due to (or as a consequence of): anding physician and use as the burial-transit that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ ō in the past 12 months? Month Year Pregnant at time of death 2 No detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, or Attending Physician: The law requires Emphysema, Pulmonary Fibrosis Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4XX Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? 1 ☐ Yes 2 🔀 No 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4  $\square$  Nursing Home 5  $\boxtimes$  Residence 6  $\square$  Other (Specify) 1 🔲 Yes 2 🔀 No ၀ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🛮 Natural 5 Pending work? n 24 hours after death.

le Funeral Director: Af olleted filled in by the fu 1 Yes 2 No Investigation 2 Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 🖹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier pleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 To the Comple only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) D 22101 October 12, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Lloyd Halvorson, M.D.

31. Date filed (Month, Day, Year)

54

Frederick, MD 21702

arkel

1475 Taney Ave.,

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2010 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month OCtober Physician/ Year ZOIC avi E lizabellourratt 1115 M Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** <u>Washington County</u> Washington County Hospital Hagerstown 9. Birthplace (State or Foreign Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🂢 F Hours Tennessee 415-62-4647 **Director** Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland | Washington County Hagerstown 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18125 Summerlin Dr. 21740 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 X No If Yes, Give Maryland 21215-0036 1 Yes 2 X No Specify. Specify: White 3 
Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Claims Manager Insurance Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Earl Stonewall Jackson Irene Fort Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Curtis E. Surratt-husband 18125 Summerlin Dr. Hagerstown, MD 21740 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, permit. Page Department c Important: If any injury or Smithsburg Crematory 10-23-2010 |Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 1331 Eastern Blvd. North Hagerstown, MD 21742 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Myocardial Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Pregnant at time of death 1 ☐ Yes 2 № 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Certificate: To Be Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed this certificate 1 Yes 2 No Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 2 🗷 No Hospital 1 🗌 Yes 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 🗌 Yes 2 🗌 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the 29b. Signature and title of c MD 03605 30. Name and address of person who completed cause of death (Item 23a) (Type, Print Hagerstown, WH-10 alla ayam 31. Date filed (Month, Day, Year, State OCT Registrar

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		1	For State Registrar	State of Mary		artment of r tificate of L			eg. No.	0 34106	
	Physician/ Medical		1. Decedent's Name (First, Middle, Las					2. Date of Deat Month	h	3. Time of Death	
			Tamrat	Shiferaw			October	1			
	Examin	er	4a. Facility Name (if not institution, give Suburban Hospi				Location of Death		4c. County of	tgomery	
	Funeral	0	5. Social Security Number 6. Se	ex 7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Septemb		9. Birthplace (State or Foreign	
	Director	-	126-54-5889 Usual Residence of Decedent	<b>X</b> M 2 □ F 56	Yrs.			Septemb	er 8,	Country) Ethiopia	
	and show d at	. h	10a. State 10b. County	10	c. City, Town or Lo	cation				10d. Inside City Limits	
	Maryl 28a-f otifie	irec	Maryland Montgo	nery	Bethe					1 X Yes 2 No	
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Number 5014 Elm Street	Ant. 2		10f. Zip Code <b>208</b> 1	4		10g. Citizen of Wh Addis Ab	at Country? baba,Ethiopia	
	eath w	Fune	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.		ispanic Origin? (Spe an, Mexican, Puerto		14. Race -	American Indian, White, etc.	
36	after d I", <b>or i</b> kamin		1 ☐ Never Married 2 🗶 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give		1 Yes 2 X No		111000111 01011		Ethiopian	
21215-0036	nours natura ical E)	Completed by	15. Decedent's E		16a. Dece	dent's Usual Occup	ation		16b. Kind of Busi		
215	nin 72 le. han "r be Med	d mo	(Specify only highest grant Elementary/Seconday (0-12)	College (1-4 or 5+)	life. D	O NOT use retired)			Limoueir	ne Services	
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Maryland	should be file n and Mental h 7 is marked o raumatic eve		19a. Informant's Name/Relationship (7		I		and Number or Rura				
e,	and 2 Health em 27 ther tr		Martha Alemayhew  20a. Method of Disposition		20h Place of Dieny	neition (Name of	eet;Apt.2			and 20814 lity or Town, State	
Baltimore,	age 1 ent of 1 nt; If its y or o		1	Removal from State	cemetery, crei	matory or other plac	Alem Ceme	23,2014		oaba,Ethiopia	
altir	permit. P Departm Importar any injur		21. Signature of Funeral Service Linen		2:	2. Name and Addre	ss of Facility ${f R}_{ullet}$	N. Horto	n Compar	ny Morticians,	
8	o a la		Dandulah	B. How						ington,D.C.2001	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final								
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$\overset{\circ}{\phi}$	Examiner	L	Sequentially list conditions, b.								
0	sit sit	mine	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a co	onsequence of):						
0	xecute n and al-tran	Exal	that initiated events resulting in death) Last	Due to (or as a co	onsequence of):	-					
200	cate be executed physician and s the burial-transi	edical Examiner		d							
_	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit		IF FEMALE:	23c. If yes, outcome of	oregnancy				22d Data	of dollyon.	
14 Box 68	attend I for us	Physician/N	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No	1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at tir	Fetal death 3	☐ Ectopic pregnan☐ Other (specify) _				23d. Date of delivery  Month Day Year	
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<u>a</u>	es that signed I be de		Part II. Other significant conditions of	ontributing to death but i	not resulting in the	underlying cause gi	veri ii Farti.			B Probably 4 Unknown	
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feraw, Tamrat Division of Vital Records,	or Atte after de: Director in by th	Certificate:	3 ☐ Suicide 6 ☐ Could not t 4 ☐ Homicide determined		- At home, farm, st Specify)	reet, factory, office		28f. Location (S City or Town		or Rural Route Number,	
)   -	ispital o	cal C	29a. Certifier 1 Certifying Phy	rsician: To the best of my	knowledge, death	occured at the time	e, date and place, a	nd due to the cau	use(s) and manner	as stated.	
3.	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 %	Medical	(Chock 2 Medical Evan	niner: On the basis of exar se Practioner: To the be	mination and/or inve	stigation in my opin	ion, death occurred a	at the time. date ar	nd place, and due i	to the cause(s) and manner stated.	
4 1	Vaithii To th	_	29b. Signature and title of certifier			29c. Licens		:	29d. Date signed	(Month, Day, Year)	
	,		30. Name and address of person who	completed source of death	th (Item 23a) (Time		166990		10119110	)	
MZ	- 6		Vinni Juneja, M				hesda,Ma	ryland 2	0817		
	Sta		31. Date filed (Month, Day Year) OCT 1 8 2010		Signature						
	Registr	al									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 10 2010 Janda 4:30 P M lico /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Charlestown Retirement Community Catonsville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Hours Months 12/18/1914 1 □ M 2 52 F 482-03-4797 Iowa Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Desilea Evandment must be realled at 1 ☐ Yes 2√2 No Director MD Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Numbe 10f, Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. USA 709 Maiden Choice Lane 21228 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2▼ No 14. Race - American Indian, 11. Marital Status Black White etc. 1 □ Never Married 2 □ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: Specify: þ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) **Petail** Sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lena Schnormeier August F. Soaksmeier 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6179 Campfire, Columbia, MD 21045 Joyce A. Prange / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/27/2010 Hubbard, Iowa Hubbard Cemetery 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH, Inc. 21. Signature ce Licensee M01411 #112 Old Columbia Pike, Ellicott City, MD 21043 20 4 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2 ☑ No 1 ☐ Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 📆 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

711 Maiden Choice LN Cartins Unite 31. Date filed (Month, Day, Year) 32 8

and manner stated.

Registrar's Signature

29c. License number

1300

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10-08079 State of Maryland / Department of Health and Mental Hygiene William Joseph Thomas 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ 1140 hrs **Medical Examiner** October 21, 2010 William Joseph Thomas c. County of Death 4b, City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) North Beach Calvert 9214 Frederick Avenue If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Foreign Country) Months Days Hours Director /02/1955 Yrs MO 231-82-5820 1X M 2 F 55 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 X Yes 2 No imore, MD 21215-0036

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "matural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once. Calvert North Beach Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20714 9214 Frederick Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married Married 2 X No Yes 4 X Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: 3 Widowed White þ 16a, Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Concrete Superintendent Construction 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leonard Edwin Thomas Mary Louise Adams 19b. Maijing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25306 Three Notch Road 2 19a. Informant's Name/Relationship (Type, Print) Kelly Kurtz/Daughter Hollywood, MD

20b. Place of Disposition (Name of cemetery, 20636 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) Important: If) 1 Burial 2 X Cremation 3 Removal from State Chesapeake Crem. 11/1/10 Beltsville, MD 4 Donation 5 Other Specify: 22. Name and Address of Facility Raymond-Wood F.H., P.A. 21. Signature of Funeral Se ce Licensee PO Box 430, Dunkirk, MD 20754 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and /Medical Death Chronic alcoholism with cirrhosis of the liver Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician and ed for use as the burial - transit The law requires that the death certificate be executed Physician/Medical X UNPENDED AMENDED per ME G910 12/22/10 TT 27.PII Box 68760, 23d. Date of delivery IF FFMALE 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Month Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. þ 1 Yes 2 No 3 Probably 4 V Unknown Hypertensive cardiovscular disease Completed ficate has been si 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed? death? 1 🗸 Yes ✓ Yes 2 No After this certificate 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 🗸 Other: Scene ER/Outpatient 3 DOA 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 X Natural 1 Yes 2 No 5 Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town. State) determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

fo the Hospital or Attending Physician: n 24 hours after death.

The Funeral Director: A sletely filled in by the fu

Registra DHMH 17 Rev 1/2001 OCME 2006

Medical

29b. Signature and title of certifier

Russell Alexander MD. 31. Date filed (Month, Day, Year)

30. Name and address of person who complete focuse of death (Item 23a)

Assistant Medical Examiner

ALLAND.

2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

October 22, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 13 Physician/ 2010° 3:55 A. M Testerman Brian Lee Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Calvert 5561 Wells Cove Drive St. Leonard 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 7/19/1975<sup>Year)</sup> 1 🕅 M 2 🗆 F Hours Washington D.C. 217-11-2851 35 **Director** Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State filed within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🗓 No St. Leonard Maryland Calvert 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Funeral or items 23a 20685 5561 Wells Cove Drive United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. 11. Marital Status th and Mental Hygiene. 27 is marked other than "natural", or iter traumatic event, the Medical Examiner ρ 1 Never Married 2 Married ☐ Yes 2 🗓 No Baltimore, Maryland 21215-0036 White 1 Yes 2XXNo Specify: If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 X Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Service Elevator Mechanic Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ပ Betsv Bucher Paul Martin Testerman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5561 Wells Cove Drive St. Leonard, Maryland 20685 Betsy Testerman / Mother 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 10/16/2010 Port Republic, Maryland Chesapeake Highland Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, PA. 4405 Broomes Island Road Port Republic, Maryland 20676 Kyle S. Simons MO1206 23a. Part 1. Enter the disease, or complications that caused the death. not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between shock or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph sician/ TYEARS 2M disease or condition resulting in death) Medical as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for an a nonneguence of: Hospital or Attending Physician: The law requires that the death certificate be executed -transit and that initiated events resulting in death) Last Due to (or as a consequence of): burialattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) 1 Yes 2 2 9 Unknown detached the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b should be 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autonsy perform 2 No 1 ☐ Yes 2 ☐ No certificate Yes 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Hospital: 1 Tyes 2 No 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home မ this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After to completed filled in by the funera (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number m  $\Pi_{M'}$ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LRW 6 Pennsylvania 2150 Diegal 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ October Martha McFarland Tyler 2010 10:26 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Country) 6 Germany 1 🗆 M 2 🖼 F Months Days Hours Min. 54 578-80-1634 Director February Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits at Director or 28a-f s notified Frederick Maryland Frederick Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Examiner must be Funeral with 23a USA 21702 2490 Lakeside Drive items 2 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. P. by 1 Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: If Yes Give white 'natural", Completed 3 Widowed 4 Divorced Year or Dates and Mental Hygiene.
is marked other than "natur:
raumatic event, the Medical F 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Senior Teacher Education Be Page 1 and 2 should be filed vent of Health and Mental Hyg 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ္ပ Margaret Tredick Wallace McFarland 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 2490 Lakeside Drive, Frederick, Maryland 21702 Randy McElroy - husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2X Cremation 3 Removal from State Stauffer Crematory Frederick, Maryland 4 Donation 5 Other (Specify) 10-13-2010 Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland eno Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Failure Physician. -iles disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 10 babl Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): physician Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for Month Pregnant at time of death 5 Other (specify) 9 Unknown the detached 9 Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 Z No ည 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 Natural 1 Yes 2 No Accident Investigation Accide: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 wo MD51610 olima 10 10/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAD 21702 aneu Aue

State

Registrar

31. Date filed (Month, Day, Year)

10

acces

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ James Albert Taylor, Jr. Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Salisbur oasta Pi Age (In yrs. last birthday) If Under 1 Year If Under 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months July 18, 1931 1 🖾 M 2 🗆 F Hours 174-26-4841 79 Director PA Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item on a construction of the construction of 10d. Inside City Limits important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 XNo Worcester Snow Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21863 USA 7308 Shockley Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Nov. 1 2 Yes 2 No 1952 þ 1 Never Married 2 Married Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 🕅 No Specify: Year or Dates Oct. 1954 Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Marketing U.S. Dept. of Agriculture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lulu Pitts James Albert Taylor, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gwendolyn Taylor Monroe/ Niece Storm Canyon Road-Winston-Salem. NC 21706 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Salisbury Crematory 10/15/2010 Salisbury, Maryland 4 Donation 5 Other (Specify) Salisbury Sign fun of Funeral Service Licen 22. Name and Address of Facility Maryland Jollev Memorial Chapel-Road 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ monea disease or condition resulting in death) Medical Due to (or as a conjuguence of): Examiner Sequentially list conditions, Examiner if any, leading to immedicause. Enter Underlying the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death Other (specify) Unknown signed by the all be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes ☐ No 24a. Was an After this certificate has funeral director, page 2 autopsy 1 Yes 2 N 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 2 No မ 1 🗌 Yes 8 Vice 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Manney of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred injury 5 Pending Natural Investigation Accident 24 hours after deatle Funeral Director: 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one 29b. Signature and title of certifie

Registrar
DHMH 17 Rev 7/2009

SAW Buck, up

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

31. Date filed (Month, Day, Year)

OCT 1 4 2010

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 10 06- 2010 8:20 AM Georgia A. Wallace 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Calvert Calvert County Nursing Center Prince Frederick If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) MD 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Days Hours June 10, 1923 1 ☐ M 2 🗹 F 577-34-5926 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No MD Calvert Owings 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20736 USA 546 Grovers Turn Road Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2₩No 1 ☐ Yes 2 🗹 No Specify: Specify: 3 ₩idowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Georgia Giles John Adams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 546 Grover's Turn Road, Owings, MD 20736 19a. Informant's Name/Relationship (Type. Print) Freddie L Wallace - son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Moses Cemetery October 13, 2010 Lothian, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sewell Funeral Home, P.A. 21. Signature of Funeral Service Licenses 1451 Dares Beach Rd., Prince Frederick, MD 20678 oshin Approximate Interval Between Onset and Death 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last titus to for as a constrouence off Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐ Yes 22 No 27. Manner of Death Natural 5 Pending

Physician /Medical **Examiner** Examine

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

or items 23a

death with

72 hours after

filed within 7 Hygiene.

permit. Pages 1 and 2 should be filed wind Department of Health and Mental Hygien Important: If item 27 is marked other than any Injury or other traumatic according.

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Division or Vital Records,

Physician:

certificate be

notified

7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be a

Director

Funeral

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Completed

Be

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as the burial-trar attending physician nse for signed by the a d be detached f page certificate funeral director, After this

Physician/Medical

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Completed

Be

P

Certification:

Medical

2 Accident

3 ☐ Suicide 4 Homicide

9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner?

	•					1 Yes 2 No	1 ☐ Yes	2□ No	
ed to medical				26.	Place of Deat	th (Check only one)			
No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA	Other: 4	Nursing He	ome 5 Residence 6	Other (Specia	fy)	
5 □ Pending investigation		28b. Time of Injury M	28c.	Injury at Work? 1 ☐ Yes		28d. Describe how injury	occurred		
6 ☐ Could <b>n</b> ot be determined						28f. Location (Street and City or Town, State)	d Number or Run	al Route Number,	
Certifying Ph	ysician: To the best of my kno	owledge, death occu	rred at	the time, d	ate and place	, and due to the cause(s)	and manner as s	stated.	

29a. Certifier	Certifying Physician: To the best of my knowledge, de		
(Check only one)	2 ☐ Medical Examiner: On the basis of examination and/or and manner stated.	Investigation, in my opinion, death occurred at	the time, date and place, and due to the cause(s)
29b. Signature an	d title of certifler	29c. License number	29d. Date signed (Month, Day, Year)

30. Name and address of person who comp of death (Item 23a) (Type drw ) Wenville

State Registrar

To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OCTOBER Physician/ 4:25 A M WERDER ANDIZA 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** JIHNS HOPKINS BAYVIEW MEDICAL CENT BALTIMORE 8. Date of Birth (Month, Day, Ye July 15, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Social Security Number If Under 1 Year If Under 24 Hrs. 1 M 2 XX Hours Director 225-17-9437 46 England Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amportant: If item 27 is marked other than "natural", or items be notified at an injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 ☐ Yes 2xxXNo Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15957 Spielman Road 21795 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Armed Force Black, White, etc. 1 Never Married 2 X Married Completed by 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 4 Contracts Officer Government Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည John Louis Niezgoda Margaret Christina Barwick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karl K. Werder - Husband 15957 Spielman Road Williamsport, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Manor Cemetery 5 Other pecify Oct.21,2010 4 Donation Tilghmanton, Maryland Osborne Hunerally Home, P.A. 21. Signature of Funeral S 425 S. Conococheague St. Williamsport, MD 21795 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ TRACHEO INOMINATE disease or condition Medical resulting in death) Examiner month Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami and -transit **Hospital or Attending Physician:** The law requires that the death certificate be executed 24 hours after death. Cause (Disease or iinjury that initiated events Month TVODAT Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? à Records, 1 Yes 2 No 3 Probably 4 Unknown Completed . Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: ျ 1 XInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Certificate: injury 5 Pending Accident Suicide neral Director: / Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) 24 hours a Medical 29a. Certifier 1 🖰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 [ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signati 29c. License number 29d. Date signed (Month. Day. Year) PES-000 OCTOBER Name and address of person who completed cause of death (Item 23a), (Type, Print) Fastern Avenue Baltimore MD WH-12 State

DHMH 17 Rev 7/2009

Registrar

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10-08075 State of Maryland / Department of Health and Mental Hygiene Robert Daniel Wrede 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month 1004 hrs Medical Examiner Robert Daniel Wrede October 21, 2010 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Charles La Plata Civista Medical Center If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5 Social Security Number 574 7. Age (In yrs. last birthday) Funeral Months Davs Hours Director co-Tillinois July 23 47 196 <del>674</del>-64-1226 1 XM 2 F Yrs Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No imore, MD 21215-0036

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-fshow or other traumatic event, the Medical Examiner must be notified at once. Maryland Prince George Clinton Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9211 Stuart Lane 20735 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? ( Specify Yes or No 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married Married Yes Specify: White 1 Yes 2 X No specify: 3 Widowed 4 Divorced If Yes, Give Year \$ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Laborer Self Employed 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward G. Wrede, Sr. Nancy M. Jacobus 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy M. Maguire Mother 618 Cedar Blvd. Accokeek, Md 20a. Method of Disposition crematory or other place) Oct. 24 2010 1 Burial 2 X Cremation 3 Removal from State tant: Alexandria, Virginia Metropolitan Funeral 4 Donation 5 Other Specify 22. Name and Address of Facility
Williams Funeral Home, P.A.

1372 Varythorne Road, Indian M00668 M00668 4270 Hawthorne Road, Indian Head, ne disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Approximate Interval **Physician** Between Onset and only one cause on each line 6. List /Medical Complications of Chronic Alcohol Abuse Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed AMENDED 23a, pt. 11, 27 per me g911 1-20-11 vt sician/Medical attending physician or use as the burial -**X** UNPENDED 5per FH G909 11/10/ Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 2 Fetal death 3 Ectopic pregnancy Month Day Year Live birth past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown jo Unknown Phy the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? P.O. Š Crohn's Disease, Esophageal Structure With Malnutrition 1 Yes 2 No 3 Probably 4 ✓ Unknown Completed Records, 24b. Were autopsy findings available 24a. Was an autopsy performed? death? page ✓ Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical of Vital Be Other<sub>4</sub> Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 Nursing Home 5 Residence 6 Other DOA 1 Yes No 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 X Natural Division 5 Pending 1 Yes 2 No the f 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide 6 Could not be within 24 hours a To the Funeral I determined \_\_ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Sa 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E October 22, 2010 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Melissa Brassell, MD

DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

31. Date filed (Month, Day, Year

OCME

**ORIGINAL** 

ack

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 18 2ďľo Anita Amei Ayim 9:05 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner National Institutes of Health Bethesda Montgomery 8. Date of Birth (Month, Day, 04 30 Social Security Number Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs Months Days Hours Min. Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🗓 F 33 **Director** None Cameroon Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland must be notified at Director 1 X Yes 2 □ No Washington DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 20011 219 Upshur St. NW Cameroon Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian, Black, White, etc. Armed Forces 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates Specify: African 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 7: ment of Health and Mental Hygiene. tant: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Hair Stylist Self-Employed 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Christina Ateh Fineboy Ayim 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martin Ayim/Brother 1502 Haskell Dr. Ruston, Louisiana 71270 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o Ayim Family Compound 11/18/2010 4 ☐ Donation 5 ☐ Other (Specify) Ekona, Cameroon 22. Name and Address of Facility Marshall-March Funeral Home 21. Signature of Funeral Service Licensee 4217 9th St. NW Washington, DC 20011 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 12 Hours hock, or heart failure. List only one cause on each line Immediate Cause (Final Diffuse Alveolar Hemorrhage Ph\_sician/ Medical resulting in death) Due to (or as a consequence of): Examiner Primary Effusion lymphoma 6 Months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of). HIV/AIDS attending physician and for use as the burial-transil Cause (Disease or iinjury that initiated events resulting in death) Last 6 Months Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perforn death? 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yes 2 ANo Certificate: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death.

Funeral Director: After this 27. Manner of Death . Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident iniury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 230955 NY lumax October 20, 2010 Wedge 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

Bethesda,

10 Center Drive

32. Registrar's Signature

MD

Thomas Uldrick,

2010

31. Date filed (Month, Day, Year)

NOV ()

20892

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Carolyn Allen Mary 1:30 A M 26 2010 Oct Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Co. Stella Maris Hospice Center Timonium 9. Birthplace (State or Foreign Country) Baltimore Social Security Number . Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, March Funeral Months Days Hours 1 🗆 M 2 🕱 F Director 218-28-1182 76 Usual Residence of Decedent and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 ☐ Yes 2 🙀 No Edgemere MD Baltimore 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral with United States 2601 Boulevard Place 21219 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces Black, White, etc. þ 1 Never Married 2 K Married ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify If Yes, Give White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Housewife 7 Years Be and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Katherine Holle Herbert T. Brewer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2601 Boulevard Place Edgemere, Maryland 21219 Department of Health ar Important: If item 27 is any injury or other trau Mr. Martin F. Allen (Husband) OCTOBER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gdns: 10/29/2010 Middle River, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility al Home of Dundalk, 7922 Wise Ave. Dundalk Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition OVARIAN CANCER Medical resulting in death) Examiner Sequentially list conditions, Examine Dille to (or as a consequence) If any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events and the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical death certificate be Box 68760 IE EEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) 1 Yes 2 No ed by the a detached f 9 Unknown P.O. s been signed by should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 2 No Records, 1 U Yes 3 Probably 4 Unknown After this certificate has been ALLEN 24b. Were autopsy findings available prior to completion of cause of 24a. Was an , page 2 autopsy performe death? 1 ☐ Yes 2 ☐ No **Division of Vital** funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 X No 1 Yes ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗶 Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending X Natural To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 1 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and**∦**itle 29d. Date signed (Month, Day, Year)

Registrar

State

30. Name and ad

JONES.

2300 DULANEY VALLEY RD. TIMONTUM.

MD 21093

ess of person who completed cause of death (Item 23a) (Type, Print)

32. Registrary Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ October 28 2090 Karen A. Barnes 6:30 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rossville Baltimore Manor Care Rossville Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)
 MD Age (In yrs. last birthday) **Funeral** Min. Febru 20 10 950 218-54-1061 1 □ M 2 🔀 F 60 Hours Director Usual Residence of Decedent shov 10b. County 10d. Inside City Limits Ħ 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland Director ural", or items 23a or 28a-f sl Examiner must be notified Middle River Baltimore MD 1 Yes 2X No 10f. Zip Code 10g. Citizen of What Country? USA Funeral 21220 Twin River Beach Road 13080 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married 1 Yes If Yes, Give 2 No Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: White Completed 3 X Widowed 4 Divorced Year or Dates marked other than "natu matic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Smith Motors Secretarial 12th Be permit. Page 1 and 2 should be filed or Department of Health and Mental Hyg Important: If item 27 is marked othen any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Bernice Weiss Leon Jackson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 401 Sugar Berry Court Edgewood MD 21040 19a. Informant's Name/Relationship (Type, Print) Robyn Cutsail /daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemeter, crematory or other place)
Holly Hill Cemetery 11/2/10 1X Burial) 2 Cremation 3 Removal from State Baltimore MD 4 Denation 5 Other (Specify) 22. Name and Address of Facility 21. Sign vu de Funeral Service License 300 Mace Ave. Balto. Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to for as a consequence of It any seading to immedicause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi ed by the attending physician and detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ 1 Live Birth
4 Pregnant a
9 Unknown Month Year Day Pregnant at time of death g . Unknown ned by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by been signe should be o 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has , page 2 autopsy performed? 1 Yes 2 No certificate Yes 2 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 11/10 Other: မှ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 🗌 Pending Natural work? 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifig Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29d. Date signed (Month, Day, Year) 29b. Sign ature and title of certific 29c. License number DOTOBET 29,2010 70060520 ause of death (Item 23a) (Typ FRANKINA RD #208, ROSEDALE, MD-21237 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 7/2009

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 12:11 Michelle 26,2010 bobe /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Days 1 □ M 2 🔀 217-78-7130 3-11-1960 MD 50 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County ms 23a or 28a-f show must be notified at 1 X Yes 2 ☐ No MD na Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 1436 May Court 21231 USA Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 ☑ No Specify: Black ò 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade Truck Driver Fed Ex 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked Chizem Albert Bell, Sr Bertha ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If Item 27 is any injury or other trainonce. Bertha Bell-Mother 1400 Madison Street Balto, MD 21205 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-1-2010 Randallstown, King Memorial Pk 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March East F/H 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1101 E. North Avenue Balto, MD Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due to (or as a consequence of): disease or condition resulting in death) ) /Medical **Examiner** nuemonia Sequentially list conditions, if any, leading to immediate cause Enter U. Jenying Cause (Disease or injury Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Tectopic pregnancy Month Year in the past 12 months? Day Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No မ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation 1 Natural
2 Accident Injury 1 🗌 Yes 2 🗌 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (check only Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Division of Vital Records, within 24 hours after death.

To the Funeral Director Aft completely filled in by the fu

> State Registrar

31. Date filed (Month, Day, Year)

argaict

29b. Signature and title of certifier



and manner stated

MD

30. Name and ad ress of rers in who completed cause of death (Item 23a) (Type, Print)

Hayes

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

October 26, 2010

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October Physician/ 2010 2:45 P M Norbert Bittner Joseph Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Baltimore Towson Gilchrist 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Social Security Number Funeral Min. Days 1 XM 2 F Months Hours June Ť918 Director 213-14-9073 92 Usual Residence of Decedent 28a-f show 10b County 10c. City, Town or Location 10d. Inside City Limits 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene.
The should be seen a 10a. State Director 1 🗌 Yes 2 📈 No Baltimore Timonium Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Funeral 21093 USA 12261 Roundwood Rd. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ 1 Yes Sive 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White 3 ₩ Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Drug Co Representative Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Richard J. Bittner Madeline Mevd 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) <u>Susan B. Jones/ Daughter</u> 8924 Wrights Mill Rd. Woodstock, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Page 1
Department of I
Important: If it
any injury or or 1 K Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) <u>Dulanev Vallev Mem.</u> 10-30-10 Timonium, Md 22. Name and Address of Facility
Ruck Towson Funeral Home, Inc.
1050 York Rd. Towson, Md. 21204 21. Signature of Juneral Service License 23a. Part 1. Enter the diselse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ tme disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause from Inaddying Cause (Disease or linjury Examiner Due to (or as a consequence of) as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 Ne 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Month Day Year Pregnant at time of death After this certificate has been signed by the a funeral director, page 2 should be detached f q Unknown Records, P.O. Part JI. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗌 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be examiner? Other: 4 Nursing Home 5 Residence 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manper of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Medical Certificate: Natural 2 Accide 5 Pending after death. 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in by determined 24 hours a Funeral [ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completed 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) within 2 To the 29p: Signature and title of certifie License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 2010 10:00 P M John Robert Bareham Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Towson 6. Sex If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign 7. Age (In vrs. last birthday) If Under 1 Social Security Number Funeral 1√2 M 2 □ F Months Days Hours Min. OCT. 25 Mary Tand 89 220-03-2950 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiene. Important: If item 27 is marked other than "nature." 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔽 No Baltimore Upperco 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral **USA** 21155 17205 Hunter Green Road 12. Was Decedent Ever in U.S. Armed Forces?

1 □ Yes 2 □ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No Specify: 3 ₩ Widowed 4 Divorced white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Towson University Doctor of Geology Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carrie Lucretia Lambert John Edward Bareham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12 E. Seminary Avenue; Lutherville, MD 21093 Dale Bareham / nephew 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp | 11/1/2010 Towson, MD 21. Signature of Funera 1050 York Road 22. Name and Address of Facility Towson, MD 21204 Ruck Towson Funeral Home, Inc. 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or Injury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant in the past 12 pronths? 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Month Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Tyes No peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform Yes 1 🗌 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 DXNo ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence After this 27. Mapher of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural work? 5 Pending within 24 hours after deem.

To the Funeral Lirector Aft 2 Accident
3 Suicide
4 Homicide 2 🗆 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day,

2010

30/ Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra

loseph William Bea	auchamp State of Maryland / Departm	lible Ink. Ensure All Copies Are Lo nent of Health and Mental Hygiene cate of Death	2010 3412 Reg. No.
Physician/	Decedent's Name (First, Middle,Last)	2. Date of De Month	eath 3. Time of Death
Medical Examine	Joseph William Beauchamp  4a Facility Name (if not institution, give street and number)	October  4b. City, Town, or Location of Death	23, 2010 2320 hrs
·	3309 Taylor Avenue	Baltimore City	N/A
Funeral Director	5. Social Security Number 219-72-6756    Sex   7. Age (In yrs. last bir   52   52   52   52   52   52   6   6   6   6   6   6   6   6   6	thday) If Under 1 Year If Under 24Hrs. 8. Date of 8 Months Days Hours Min. 10-14	-1958   Sirthplace (State or Foreign Country) Maryland
re Maryland or 28a-f show any fied at once, Director	10a. State 10b. County 10c. City, Town	n or Location Parkville 10f. Zip Code	10d. Inside City Limits 1 Yes 2 X No 10g. Citizen of What Country?
th the Maryland 23a or 28a-f sh notified at ond		21234	USA
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	3 Widowed 4 Divorced lif Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? ( Specify Yes or North Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 Yes 2 X No specify:	white, etc.  specify: White
hours natur Exam	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
5-0036 ed within 72 hours tygiene. other than "natu the Medical Exan Completed	12	Inspector	AAI
5-00 ed wit tygien other the Mo	17. Father's Name (First, Middle, Last)	18.Mother's Name (First, Middle	
121; I be fill ental F arked vent, J		Margaret B. B	
MD 21 nd 2 should alth and Me m 27 is ma sumatic ev	David W. Beauchamp, Jr Brother		Maryland 21234
MOFe, Pages 1 ar tent of Her turt If ite	1 X Burial 2 Cremation 3 Removal from State crema	of Disposition (Name of cemetery, tory or other place) od Cemetery 10-28-2010	20c. Location - City or Town, State  Baltimore, Maryland
Balti permit. Departn Importi injury o	21. Signature of Jun ral Service Licensee	I I a a sa a sa al I Distrati. Trans	5 Harford Road timore, MD 21214
Physician Medical xaminer	23a. Part I. Enter the disease, or of mplications that caused the death. Do n failure. List only one cause in each line.  Immediate Caus. (Final disease a. Contact Gunshot Wound of		rrest, shock, or heart Approximate Interval Between Onset and Death
Name of the last o	or condition resulting in death)  Due to (or as a consequence of):		
ted 	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated		
executed an and al - transit	events resulting in death) Last Due to (or as a consequence of):		
0, be ex sician burial			
Sox 68760, death certificate be attending physici for use as the buringstyle b	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 4 Pregnant at time of death 9 Unknown	2 Fetal death 3 Ectopic pregnancy 5 Other (Specify)	23d. Date of delivery Month Day Year
P.O. Bc so that the dec gned by the a detached fe			tobacco use contribute to the cause of death?  es 2 V No 3 Probably 4 Unknown
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buniedical Certification: To Be Completed by Physician/Med		1 <b>✓</b> Yes	opsy prior to completion of cause of formed?
fital sician is certilirector	examiner?	26.Place of Death (Check only one)  Outpatient 3 DOA Other Nursing Home 5	Residence 6 V Other: Scene
in of Vi nding Physi ih. After this e funeral dir ion: To	27 Manner of Death 290 Data of Injury 29h		e how injury occurred
Division o to the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune edical Certification:	2 Accident Investigation 3 🗸 Suicide 6 Could not be determined (Specify) Church	farm, street, factory, office building, etc. 28f. Location or Town,	(Street and Number or Rural Route Number, City State) Avenue, Baltimore, MD
To the Hosp within 24 ho To the Fune completely fi		eath occurred at the time, date and place, and due to the ca investigation, in my opinion, death occurred at the time, dat	
M M	29b. Signature and title of certifier	29c, License number O.C.M.E.	29d. Date signed (Month, Day, Year) October 24, 2010
)	30 Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner	111 Penn Street, Baltimore, MD 21201	1
State Registra	31 Date filed (Month, Day Year) 32 Registrar's Signature	Kel	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death 2. Date of Death 3. Time of Death Month Year Physician Baumel Janice October 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A The Johns Hopkins Hospital Baltimore City 5. Social Security Number 8. Date of Birth (Month, Day, Year) 4/21/1930 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** 1 . M 2/XF 215-22-4750 80 MD Director Usual Residence of Decedent 10d, Inside City Limits 10a State 10c. City. Town or Location show 10b. County r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 1 Yes 2XXNo Director MD BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip-Code 10a. Citizen of What Country? 21117 USA 8019 VALLEY MANOR ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes XXX No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify. WHITE 2 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) OWN HOME 12 HOMEMAKER 1 and 2 should be filed w
 Health and Mental Hygier
 tem 27 is marked other tf 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be COHEN REBA **FARBER** SAMUEL ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8019 VALLEY MANOR RD; OWINGS MILLS, MD EDWARD BAUMEL / HUSBAND permit. Pages 1 and 2 Department of Health Important; If item 27 any Injury or other tra once. 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10-29-2010 BALTIMORE, MD MIKRO KODESH BETH ISRAEL 21. Signature Funeral Service Liberises 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD; BALTIMORE, MD 21208 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Myccardial inf infaction /Medical Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events death certificate be executed use as the burial-tran resulting in death) Last Due to (or as a consequence of) physician Box 68760. Physician/Medical IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) be detached Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed' 2 X No 1 ☐ Yes 2 ☐ No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) Hospital: 1 ☐ Yes 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After the 28c. Injury at Work? Certification: 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) 29a. Certifier X CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

Garles

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

37. Registrar's Signature

Jate 31. Date filed (Month, Day, Year) Res-000

October 27

600 North Wolfe St, Baltimore, MD, 21287

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Bernice Walters Collins October 0 2010 12:45P <sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Heart Homes Assisted Living Linthicum Heights Anne Arundel If Under 1 Year If Under 24 Hrs Social Security Number 8. Date of Birth (Month, Day, Yea 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Days Hours South Carolina 85 Director 215-22-5733 Yrs Usual Residence of Decedent 28a-f show 10b. County 10a. State filed within 72 hours after death with the Maryland the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 V No <u>Maryland</u> Anne Arundel Linthicum Heights 6 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a 804 South Camp Meade Road 21090 **USA** 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 9 þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 **X**No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify "natural" Completed 3 ☑ Widowed 4 ☐ Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation permit. Page 1 and 2 should be flied within 721 Department of Health and Mental Hygiene. Important: If fleen 27 is marked other than "na any injury or other traumatic event at a once. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ John Walters Lessie Watts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marian Louise Collins, Daughter 7620 Ayrshire Court Severn, Maryland 21144 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State Metro Crematory Inc. 4 ☐ Donation 5 ☐ Other (Specify) 11/01/10 Baltimore, Maryland 21. Signature of Funeral Service Licensee Thomas Gregor 22. Name and Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each life. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Pall Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or migury that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) Month To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: Assisted မူ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Deatl 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death.

Funeral Director: After 1 Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Let Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title o 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of pers

ompleted cause of

32. Registrar's Signature

(Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 3.30 AM LARK -Vis 2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore FUTURECARE IRVINGTONKNOLLNI 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 6. Sex **Funeral** Min 1 □ M 2 🔀 F 099-20-2953 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show traumatic event, the Medical Examiner must be notified at NY Director Yes 2 No tork 10g. Citizen of What Country Street and Number ŏ 10037 "natural", or items 23a enox Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Blac Specify: ð 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industr (Give kind of work done during most of working life. DD NOT use retired) Is marked other than dary (0-12) College (1-4or 5+) and 2 should be filed withi ealth and Mental Hygiene. Be formant's Name/Relationship (Type. Print) Nephew) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health au
Important: If Item 27 Is
any Injury or other trau 2/2/8 harles Thornton, or. 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State Baltimore, 5 ☐ Other (Specify) 4 Donation 21. Signiture of Funeral Service Licensee 23a. Part 1. Enter the tisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DAYS **Physician** NEUMONIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a 1 □Yes 2 □No P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by DSCLEROTIC CARDIOVASCULAR 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 The certificate 1 □Yes 2 No 1 Yes 2 No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1☐ Yes 21 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After thi 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending Natural 2 Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier D42510 asanthakumami 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 576. N. ROLLING RD # 108 MD21228 TUA

DHMH 17 Rev 1/2001

Registrar

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 2:10 AM 2010 Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death County of Death Prince Regional Hospita aurel If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🕏 F Apr 17 Months Days Hours Min Director 218-24-9367 82 **T**928 MD Usual Residence of Decedent show ge 1 and 2 should be filed within 72 hours after death with the Maryland to of Health and Mental Hygiene. It fiew T27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛣 No MD Anne Arundel Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3504 Cherry Blossom Crossing 20724 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify. Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Health Care LPN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ (Unknown) Clarence Costley Geneva 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Mona Benson (Niece) 3504 Cherry Blossom Corssing, Laurel, MD 20724 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Department of Important: If any injury or 9 4 ☐ Donation 5 ☐ Other (Specify) Fairview Cemetery 11/5/2010 Taylorsville, MD 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA 21. Signature of Funeral Service Licenses MOO 764 PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final enysician Respirator disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Pneumonia Sequentially list conditions, if any least sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Examiner Due to for as a gunsequence of Hospital or Attending Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) To Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 m/onths? 1 ☐ Yes 2 🖟 No Month Year Dav Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Director: After this certificate Yes 2 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 🔲 Yes 2 No 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury 28c. Injury at 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined within 24 hours a To the Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature a 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

aurel Regional Hospital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Munim

WOY 0 1 2010

31. Date filed (Month, Day, Year)

D55861

October 29, 2010

7300 Van Dusen Road

Laurel

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		1 - State Certificate of Death					Re	g. No.	010	J4121			
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Medic	al		Dolores		therine	e Ca	amponesch:			<u>October</u>	T	0 <u>10</u>	4:45 A <sup>M</sup>
Examin	er	4a. Facility Name (if			nber)		4b. City, Town, or				4c. Count	•	
Funeral		5. Social Security N		Sex	7. Age (In yrs.	. last birthday)	Severna If Under 1 Year	a Par If Under		8. Date of Birth		Arui 9. Birt	nDIGE I
Director		213–28–4 Usual Residence of	-2/4	1 □ M 2 💢 F	79	Yrs.	Months Days	Hours	Min.	(Month, Day, Year) Jan. 20, 1931 Ma			aryland
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of To	eral Service Lice	nsee		2	2. Name and Addres	ss of Facilit	y Ruc	k Towson	Funer	al H	ome, Inc.
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Physi this cral din	<u>۱</u>	1 Yes 2 X	No	1 28a. Date		ER/Outpatie							Residence
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Luneral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Medical	(Check 2	Medical Exa	miner: On the bas	sis of examinati	on and/or inves	occured at the time, stigation, in my opinio death occurred at the	n, death oc	curred at	the time, date and	place, and du	ue to the c	ause(s) and manner stated,
To the within to the comp.	2	29b. Signature and	title of certifier,		TO THE DEST OF	ny knowledge,	29c. License		and hisc		d. Date signe		
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day October 19, 2010 1623 hrs Medical Examiner Crossont Lynn Ivy 4a. Facility Name (if not institution, give street and number) c. County of Death 4b. City. Town, or Location of Death **Baltimore County** 4 Dunnett Court Nottingham If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Foreign Months Days Hours Director 218-08-9962 March 11,197 Country) 1 M 2 XF 40 Usual Residence of Decedent 10d Inside City Limits 10a State 10h Counts 10c. City, Town or Location MD 1 Yes 2 X No Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shoi injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore Dunda1k Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2033 Inverton Road 21222 United States Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Race - American Indian, Black. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 Married Armed Forces? White, etc. f Yes, Give Year 1 Yes 2 X No specify: White 4 Divorced Specify: ş 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Years Counselor Maryland General Hosp 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Eva E. Eichelberger Be Geroge E. Engelbach

19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Eva E. Engelbach (Mother) 2033 Inverton Road Dundalk, MD 21222 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery crematory or other place) Burial 2 X Cremation 3 Removal from State Towson, Maryland Donation 5 Other Specify Service Corp 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, 21. Sighature of Funeral Service Licen Dundalk, Maryland 7922 Wise Ave. e dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only Between Onset and cause on each line /Medical Death Combine drug (methadone and citalogram) Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): intoxication Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical signed by the attending physician at be detached for use as the burial -X UNPENDED AMENDED 23a,27.28a-f,per M Eg910 12/7/10 TT Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify, 1 Yes 2 No 9 V Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed certificate has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? . death? ✔ Yes 2 No 1 🗸 Yes 2 No or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene this 1 🗸 Yes 2 28a. Date of Injury (Month, Day,Year) After 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural unk 1 Yes 2 X No Pending To the Funeral Director: completely filled in by the Fd 10/19/10 Fd 4:20 pm Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Dunnett Court 6 X Could not be Suicide or Town, State) 4
Notingham, residence determined (Specify) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E October 20, 2010 OCME 30. Name and address of person who completed cause of geath (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

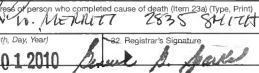
State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State Registrar 31. Date filed (Month, Day, Year)

30. Name and add



DHMH 17 Rev 7/2009

28

20/0

PARTHORE, UM ZIZO 4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 27,2010 **Physician** Р 5:00 Hap Dam /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lorien Nursing and Rehab Center Columbia . Howard If Under 1 Year | If Under 24 Hrs 8. Date of Birth 11/24/1946 9. Birthplace (State or Foreign Country) Vietnam 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min. 1 □ M 2 🔽 F 215-94-2285 63 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

em 27 is marked other than "natural", or Items 23a or 28a-f show the traumatic event, It. M. officel Examinar Inset by northed 3 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21042 USA 4740 Leyden Way by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Tes 2 If Yes, Give 2 Year or Dates: 1X Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 Specify: Asian 1 ☐ Yes 2 🛣 No 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dam Cuu Dang Muon ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa M. Dam/ Sister permit. Pages 1 and:
Department of Health
Important: If item 27;
any Injury or other tra
once. 4740 Leydon Way, Ellicott City, Maryland, 21042 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial 11/1/2010 Elkridge, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gary L. Kaufman Funeral Home, Ind. 7250 Washington BLvd., Elkridge, Md. 21075 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Breast Cancer **Physician** unknown disease or condition resulting in death) /Medical s a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit P.O. Box 68760 resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 2 No 1 🗌 Yes 3 Probably 4 Unknown diabetes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural Accident 1 ☐ Yes 2 □ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in the cause of examination and the cause of the cause o 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 10-28-10

Registrar

State

edarlane Columbia MD 21044

leted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Diags <u>iun</u>K™ Medical 4b. City, Town, or Location of Death Gurnie nne Arunde Examiner Anne Anne Washington HOSPITA Funeral yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign ntli Da Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Ifem 27 is marked other than "nature" any injury or other traumatic events. 10a. State City, Town or Location 10d. Inside City Limits Director Hasadena 1 🗆 Yes 2 📉 No 10g. Citizen of What Country? Funeral Drive Holmes Pun USA-12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 XYes 2 No Black, White, etc. 1  $\square$  Never Married 2  $\square$  Married 1 X Yes 2 If Yes, Give Year or Dates Completed by 1 Tyes 2 No 3 Widowed 4 Divorced 13*lac*K 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Teacher Be 17. Father's Name (First, Middle, Last) ည Son Village avrhon Terrace Method of Disposition Place of Disposition (Name of cemetery, crematory or other p 1 Burial 2 ☐ Cremation 3 ☐ r 4 ☐ Donation 5 ☐ Other (Specify) Burial 2 Cremation 3 Removal from State ownsville 21. Signatur Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition Medical resulting in death) Examiner 7-month Sequentially list conditions, if any, leading to miniculate cause. Enter Underlying Cause (Disease or linjury iner Due to (or as a consequence or): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Oirector, After this certificate has been signed by the attending physician and completed filled in by the Inneral director, page 2 should be detached for use as the bunal-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 1  $\square$  Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No Certificate: To 1 🗌 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital of within 24 hours at To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier 29c. License number D0064178 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harvinder Singh, MD 203 Hospital Drive, #312, Glen Burnie, MD 2016/

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 2010 Charles Davis Oct. 9:40 P M R 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A Johns Hopkins Bayview Medical Ctr. Baltimore City 5. Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min 1X M 2 D F Aug. 6,1939 North Carolina 71 217-38-6565 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Dunda1k Baltimore 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 1916 Larkhall Road 21222 United States 12. Was Decedent Ever in U.S . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Force Black, White, etc. 1 Never Married 2 X Married ☐ Yes 2 ☐ No 1 Yes 2 No Specify: If Yes, Give 3 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Good Samaritan Elementary/Seconday (0-12) College (1-4 or 5+) Hospital Driver 10 Years 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Opal Guffey Leon Schrock 19a. Informant's Name/Relationship (Type, Print) b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1916 Larkhall Road Dundalk, Maryland 21222 Mrs. Sharon L. Davis (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 K Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) of Faith Cem 10/28/2010 Baltimore, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
Dundalk Maryland 21222 22. Name and Address of Facility SOCI Dundalk. Maryland Wise Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Infarction Onset and Death Myocardial resulting in death) Atherosclerotic Cardiovasan lar disease ucars Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Dav Pregnant at time of death 1 Yes 2 L 9 Unknown Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Cerebral palsy 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 XNo 26. Place of Death (Check only one)

Physician/ Medical Examiner

sician and burial-transit

been signed by the attending physician should be detached for use as the buria

has

certificate

after death.

Director: After this

24 hours a

To the within 2

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Physician/

Medical

Examiner

**Funeral** 

Director

ms 23a or 28a-f show must be notified at

9

1 and 2 should be filed within 72 hours aft of Health and Mental Hygiene.
item 27 is marked other than "natural", other traumatic event, the Medical Exa

permit. Page 1 a
Department of I
Important: If ite
any injury or ot

Director

Funeral

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Completed

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MD

death with the Maryland

within 72 hours after

ltimore, Maryland 21215-0036

Examiner Physician/Medical b Completed Be ၉ Certificate:

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebro vascular disease

25. Was case referred to medical examiner?

1 X Yes 2 No Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury X Natural 5 Pending

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at 28d. Describe how injury occurred

work?
1 Yes 2 No M 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifie ilson mo

Investigation 6 Could not be

determined

D4027

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5601 Loch Raven Blud Baltimore MD Z1239 Thomas S.Wilson Mh 31. Date filed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

Accident

Suicide

4 Homicide

29a, Certifier



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Yea **Physician** 1:05A м Defatta 2010 leanor 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Manor Care Rossville Rossville Baltimore Co. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Min. 1 □ M **X**XF Months Days Hours Yrs Director 215-16-7076 87 Aug. 6,1923 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Exactions must be notified at 1 ☐ Yes 2 🖺 No Director MD Rosedale Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 6 Days End Court 21237 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: <u>م</u> 3 ☑ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Years <u>Homemaker</u> Own Home 7 Is marked other traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be of Health and Mental f Item 27 Is marked o Frank Golembiewski Bertha Helstowski ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Daughter) 6 Days End Ct. Rosedale, Maryland 21237 Department of Health Important: If Item 27 any injury or other to once. Arlene Hood 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Rosary Cemetery 10/30/2010 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 0 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> icate has been sig 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 □No 1 ☐Yes 2 MNo 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 1 No 24 hours after death. Funeral Director: A 2 Accident filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12111615 10177110 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21201 Goldsboras

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	amend #1 State of Mar  State Registrar		rtment of He tificate of D	eath	Reg. N	2010	34135				
	Physicia	1/	1. Decedent's Name (First, Middle, Last)	Samue1	Fox		Date of Death Month	25 25 Year	3. Time of Death				
$\bigcirc$	Medic Examin	er '	la. Facility Name (if not institution, give street and number)  NORTH OAKS HEALTH CENTER		4b. City, Town, or I	RE	Date of Birth	BALTIMO					
	Funeral Director		5. Social Security Number $\begin{bmatrix} 6. \text{ Sex} \\ 1 \text{ $\stackrel{\frown}{X}$} \text{ M 2} \ \Box \text{ F} \end{bmatrix}$ 7. Age (I) Usual Residence of Decedent	n yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	Hours Min. 1	27087192	21 Cou	ntry) MD				
	ne Maryland or 28a-f show notified at			0c. City, Town or Loc MONKTON	10f. Zip Code		10g.	Citizen of What Cou	10d. Inside City Limits 1 ☐ Yes 2 ☒ No untry?				
036	nit, Page 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 29a or 28a-f show ortant: If item 27 is marked other than "matural" or items 20a or 20a-f show injury or other traumatic event, the Medical Examiner must be notified at injury or other traumatic event, the Medical Examiner must be notified at e.e.	ed by Funeral	7 HENDERSON HILL COURT  11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced  12. Was Decedent Evern Armed Forces? 1 □ Yes 2 ☒ Nif Yes, Give Year or Dates.	0 1	f Yes, specify Cubar □ Yes 2 🏋 No		n, etc.)	1 - 7 - 1	, etc. IITE				
21215-0036	ithin 72 hour ene. r than "natu the Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12) College (1-4 or 5+	(Give F	dent's Usual Occupa kind of work done d O NOT use retired) NER	uring most of working	I		IKLIN & CO.				
and 2	be filed w ental Hygi ked othe ic event,	To Be	17. Father's Name (First, Middle, Last)  LOUIS F	OX		18. Mother's Name (Fin			GERBER				
, Maryland	nd 2 should ealth and M n 27 is mar er traumat		19a. Informant's Name/Relationship (Type, Print)  DAVID L. FOX/SON	7 HI	ENDERSON	HILL COURT	MONKTO	N, MD 2	1111				
altimore,	permit, Page 1 and 2 Department of Health Important: If item 2 any injury or other 1 once.		20a. Method of Disposition  1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	HAR SINA	I CONG.	10/28/2	2010	OWINGS MI	ILLS, MD				
Balt	permit Depart Impor any in		21. Signature of Funeral Service Licensee  23a. Part 1. Enter the disease, or complications that caused		2. Name and Address 8900 REIS	TERSTOWN RO	DAD, PIK		MD 21208				
	Ph_sician/  Medical  Examiner	dical Examiner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, eaching to immediate cause. Enter Underlying	consequence of):	imer	s Di	5 0 0 5 0	2	Interval Between Onset and Death				
09	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		dical	dical	dical	dical	dical	d	consequence of):				
Box 687	death certifics he attending p ed for use as t	by Physician/Me	FFEMALE: 23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3	☐ Ectopic pregnan☐ Other (specify) _	су		23d. Date of de Month	elivery Day Year				
P.O.	res that the signed by t	d by Phy	Part II. Other significant conditions contributing to death b	ut not resulting in the	underlying cause g	iven in Part I.			o the cause of death?  Probably 4  Unknown				
Division of Vital Records,	ne law requi se has been age 2 should	Completed					24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of es 2 \sum No				
a H	ian: The	Be C	25. Was case referred to medical		Lou	Place of Death (Check o							
ı of Vit	ing Physica La Affer this ce uneral directions	은	1 Yes 2 No 1 Inpati	ent 2 ER/Outpati ry 28b. Time y, Year) injury	of 28c, Inju		e 5 Residend d. Describe how	ce 6 Other (Spe injury occurred	ecify)				
ivisior	or Attend after death Director: /	Certificate:		ury - At home, farm, s c. (Specify)		28	Bf. Location (Stre City or Town,	et and Number or F State)	Rural Route Number,				
Ω	e Hospital 124 hours e Funeral	Medical	29a. Certifier (Check only one) 3 Certifying Physician: To the best of Check only one) Certifying Nurse Practioner: To the		estigation, in my opi e, death occurred at	the time, date and place,	and due to the c	ause(s) and manner	as stated.				
	To the within To the	2	29b. Signature and title of certifier Hales		29c. Licer	10718	29	d. Date signed (Mon	2010				
10			30. Name and address of person who completed cause of the Harry M. Walen 1838	reene Tre	e Road St	e 300 Bal	to,Md 21	208					
	S Regis	tate trar	31. Date filed (Month, Day, Year) 32. Registr	rar's Sanaturo (	le								

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #29d Per FH G909 11/08/10 JH State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OCTOBER SYLVAN GILBERT FRIEDMAN 2010 11:20P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TOWSON **BALT IMORE** GILCHRIST HOSPICE CARE If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**XX**M 2 □ F Months Days Hours Min 0672571942 Director 215-42-0938 68 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director MD **BALTIMORE** OWINGS MILLS 1 🗌 Yes 2 🏌 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3420 ASSOCIATED WAY. 21117 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates WHITE 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other tran "n: any injury or other traumatic event, the Medic once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) BUSINESS ADMINISTRATOR BALTIMORE CONVENTION CTR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ **ISADORE EDITH ASHMAN** FRIEDMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STANLEY FRIEDMAN/BROTHER 12240 ROUNDWOOD ROAD,#609 TIMONIUM. MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State MTKROPKODESH<sup>P place)</sup> BETH ISRAEL 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/29/2010 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Metustatio Punckeatic cancer disease or condition resulting in death) month Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 / the attending pt ched for use as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death 1 Yes 2 g Unknown a I IInknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has funeral director, page 2: performed? Yes 2 No 2 🗆 No 1 Tyes 25. Was case referred to medical B 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 XNo |은 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA HOSPIC P 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Matural injury 5 Pendina in 24 hours after death.

In Funeral Director: All pleted filled in by the fu Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 only one) 29b. Signature and title of certifie 00070635 <del>10/</del> 10/28/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 charles Loura Pate 0701

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

NOV 0 1 2010

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 2010 November ზ1 1:25  $A^{M}$ Sylvia Maria Goodson Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Center for Hospice Towson Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 1 M 2 XX Months Days Hours Min. 03/29/1964 257-53-4325 Germany Director 46 Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland must be notified at Director 1 Yes 2 XNo Maryland | Baltimore Essex 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral items 23a 21221 U.S.A. 1219 Bayside Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. traumatic event, the Medical Examiner Armed Forces? ō þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 🏋 No Specify: Specify: White "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumation. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Export 5+ Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Maria Hasselberg Bernhard Herde 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeffrey Goodson (Husband) 1219 Bayside Road, Baltimore, Maryland 21221 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 Durial 2 Cremation 3 Removal from State Bayview Crematory, Inc. 11/03/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A.
1407 old Eastern Avenue, Essex, Maryland 21221 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between or heart failure. List only one cause on each line nset and Death Immediate Cause (Final Physician/ ongli dise e or condition re ting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or linjury or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician the dorugh the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year No Pregnant at time of death detached Unknown g Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? s been signed the should be det þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 performed?

Yes 2 10 N 2 No 1 Yes certificate 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: MARRILL 1 Inpatient 2 ER/Outpatient 3 IDOA မ this 27. Manner of Dooth 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1/Natural Certificate: injury 5 Pending n 24 hours after death. e Funeral Director: Affolieted filled in by the fur 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 2010 itle of certifie 29b. Signature a 6701 N. Charles St Tanson M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANON 31. Date filed (Month, Day, Year) 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 2010 10 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** Town, or Location of Death 4c. County of Death (throne Monora ver 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 2 F Months Days Hours Min. May 29, 1925 West Virginia 85 Yrs **Director** 234-40-3374 Usual Residence of Decedent 28a-f shov 10a. State 10b. County filed within 72 hours after death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2X No Md. Balto. Nottingham 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 9303 Perglen Road 21236 Was Deceud.
Armed Forces?
Ves 24 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates. Specify: Completed 3 ♥ Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Home 8th Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve once. 2 Mabel A. Leatherman Harry V. Webb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9303 Perglen Road Nottingham, Md, 21236 DTR Susan D. Welsh 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Lorraine Park 11-1-2010 Woodlawn, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Schimunek Funeral Home 22. Name and Address of Facility 9705 Belair Road Nottingham, Md, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between
Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter churchying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) 9 | Unknown 9 \ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas autopsy performed 1 Yes 2 No Yes 2 🖼 Be ( 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Mann f Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural injury 5 Pending 2 Accident 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined e Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier

Registrar
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31. Date filed (Month, Day

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0ctober 30, 2010 LEE GOETZKE 7:35P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore 5. Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Min May 25, 1918 1 □ M 2 🙀 F Hours 218-01-1928 Marviland 92 Director Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits by Funeral Director 1 X Yes 2 ☐ No Maryland None Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3900 North Charles Street 21218 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes a No Specify: If Yes Give 3 Widowed 4 Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Secretary State of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Arthur R Goetzke Theresa Wimmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8800 Walther Blvd Baltimore, Maryland 21234 Joseph Patrick Oates PR Method of Disposition

Method of Disposition

Method of Disposition

Method of Disposition

Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Loudon Park Cemetery 11/04/2010 | Baltimore, Maryland ☐ Donation 5 ☐ Other (Specify) gnature of Funeral S 22. Name and Address of Fa Mixtchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ KIDWOUN. disease or condition Medical Examiner resulting in death) Due to (or as a consequence of): الكنفقة Sequentially list conditions Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury ougesti that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) \_\_\_ 3 in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 1 Yes 2 g 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 N 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 A Other (Specify) Hospital: ျှ 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? s after death. 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town. State within 24 hours aff
To the Funeral Di
completed filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my californ death occurred. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 71040 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 17 ARATHT KUMAR CHARLES 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

			Amend #26, p	Type or Print in Blace State of Maryland / I AMEND TTEM# 17 , 18	k Indelible Ink. Ensure Pepartment of Health and 8,19a,perFH,6909,11 Certificate of Death	All Copies A Mental Hygie /8/2010, WS	re Legible.
	Physicia Medic		1. Decedent's Name (First, Middle, Last,		1	2. Date of Death Month	Day Year 3. Time of Death
7	Examin			Spice	4b. City, Town, or Location of Dea	th	Salt Mou
H	Funeral Director		5. Social Security Number 6. Sep 6. Sep 1 Usual Residence of Decedent	Malle 10	Aday) If Under 1 Year If Under 24 Hr Months Days Hours Mir		9. Birthplace (State or Foreign Country)
:	Maryland 28a-f shov notified at	Director	10a. State 10b. County Howa	10c. City, Town	lumbia		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
:	th with the ns 23a or must be r	Funeral C	9013 Flicked	Place	10f. Zip Code 21045		Citizen of What Country?
9003	permit. Page I and 2 should eithed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene inmportant if firem 27 is man ed other then "natural", or items 23a or 28a-f show any injury or other traumati event, the Medical Examiner must be notified at once.	by	1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (s If Yes, specify Cuban, Mexican, Pue 1  Yes 2 No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: Black
	within 72 ho giene ner than "na t, <u>the</u> Medic	e Completed	15. Decedent's Edi (Specify only highest grace Elementary/Seconday (0-12)	College (1-4 or 5+)	Decedent's Usual Occupation (Give kind of work done during most of work iffe, DO NOT use retired)	orking 16b	o. Kind of Business Industry
Maryland	should e filed h and Mental Hy 7 is mar ed oth raumati event	To Be	17. Father's Name (First, Middle, Last) D	ust	18. Mother's N	Ta Maidle Maid Eli C	en Surname) 4 att Son
	and 2 shou Health and tem 27 is m ther traum;		19a. Informatis Name/Relationship	mecl $90$	Mailing Address (Street and Number or S	ural Route Number, City	or Town, State, Zip Code) umble, MD 21045
mor	permit. Page 1 a Department of I Important: If ite any injury or ot		20a. Method of Disposition  1	Removal from State	Disposition (Name of y, crematory or other place)  22. Name and Address of Facility	Date 200 +	Location - City or Town, State
Ba	permit. Departr Imports any injt		Muan (C)	towell of	16226 Guil-Ford	Rel Tel	Sup, MD 20794
	hysician Medical Examiner		shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cause on each line.	of Lyme Pisease		Approximate Interval Between Onset and Death Years
8	n and al-transit	Examiner	Sequentially list conditions, if any, leading to immediate cauce. Exter Underlying Cause (Disease or linjury that initiated events	Due to (or as a consequence or	n):		
760			resulting in death) Last	Due to (or as a consequence of	f):		
P.O. Box 68760	y the attending physicia ched for use as the bur	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3		23d. Date of delivery Month Day Year
ds, P.O	s been signed by the a should be detached f	by	Part II. Other significant conditions cor	tributing to death but not resulting in	the underlying cause given in Part I.		to use contribute to the cause of death?
Division of Vital Records,	Inspired a Areanning Frystodin. The law requires that the 124 hours after death.  Funeral Director: After this certificate has been signed by the funeral director, page 2 should be detached filled in by the funeral director, page 2 should be detached.	• Completed	25. Was case referred to medical			24a. Was an autopsy performed 1 Yes 2	24b. Were autopsy findings available prior to completion of cause of death?  No 1 □ Yes 2 □ No
of Vita	r this cert	e: To Be	examiner?	ospital: 1  Inpatient 2 ER/Out 28a. Date of injury 28b. Ti		Home 5 Residence	
Sion C	s after death. I Director: After to in by the funera	Certificate:	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be		jury work?  M 1  Yes 2 No	28d. Describe how in	
DIVIS	within 24 hours after  To the Funeral Direct  completed filled in by		4 ☐ Homicide determined  29a. Certifier 1 ★ Certifying Physic	building, etc. (Specify)	eath occured at the time, date and place,	City or Town, Sta	
	thin 24 h	Medical	(Check 2 \( \subseteq \text{Medical Examination} \)	er: On the basis of examination and/or	investigation, in my opinion, death occurred at the time, date and p	l at the time, date and pla lace, and due to the caus	ace, and due to the cause(s) and manner stated. se(s) and manner as stated.
٩	. № <b>6</b> 0		Zn nt	2 Puo	29c. License number  DD0 70 6 3 9		Date signed (Month, Day, Year)
	6		30. Name and address of person who co	mpleted cause of death (Item 23a) (To 270) N Charles	ype, Print)		
F	Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's Signature	Ked	1.00	/

10-08137 Jerome Hall Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Death	Reg.	No.	
physicis	n/	n/ 1. Decedent's Name (First, Middle,Last)  2. Date (Month)	n D	Day Year	3. Time of Death
Medical Examii	ıer	er Jerome Hall Octo	ber 24,	2010	1158 hrs
		4a. Facility Name (if not institution, give street end number)  1505 E. Lafayette Avenue  4b. City, Town, or Location of Death  Baltimore		4c. County of	
Funeral	T	5. 555.6.		- 11	9. Birthplace (State or Foreign
Director		218-26-4919 1X M 2 F 80 Yrs.   Motitus Days   Hours   Will 7-	24-1	1930	Country) MD
	ļ	Usual Residence of Decedent  10a State 10b, County 10c, City, Town or Location			10d. Inside City Limits
w any	1	Politimore			1 X Yes 2 No
Maryland 28a-f show d at once.	١	MD na Baltimore  10e. Street and Number 10f. Zip Code	100	. Citizen of Wha	
l el re l	Director	1505 E. Lafayette Street 21213	109.	USA	, dearny .
ms 23	Funeral	11. Marital Status  12. Was Decedent Ever in U.S.  13. Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, et		14. Race - White,	American Indian, Black, etc.
r death	핊	Armed Forces?  If Yes, specify Cuban, Mexican, Puerto Rican, et al., Specify Cuban, et al.,	,		Black
s afte	<u>a</u>	or Dates:	110	Specify: 6b. Kind of Busi	ness/Industry
hour "natu	ted	Elementary/Secondary (0-12) College (1-4 or 5+)			
36 hin 7 than edical		Medical Specialist		Army	Į.
215-0036 be filed within 7 ntal Hygiene, rked other than ent, the Medica	Completed	17. Father's Name (First, Middle, Last) 18.Mother's Name (First, M		-	
215 be fill mtal H rked	å	Robert Hall Lillian A			
21 hould I nd Mer is mar	2	F		er, City or Town, Md 2123	
MD and 2 sho alth and 2 is raumati	-	Darlene Hall-Daughter   246 Bethel Court Balt   20a. Method of Disposition   20b. Place of Disposition (Name of cemetery,   Date			City or Town, State
Ore, es la of He of He title		1 V Burial 2 Cremation 3 Removal from State crematory or other place)			
Baltimore, permit. Pages I ar Department of Hee Important: If ite	ļ	4 Donation 5 Other Specify: Arlington Nat Cem 11-1-2  21 Signature of Funeral Service Licensee			gton, VA
Bal permi Depar Impo		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Marc  1101 E. North Aven	h Ea	ast F/I Balto	
Physician	$\dashv$	23a. Part I. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirat			t Approximate Interval
Medica		failure. List only one cause on each line.  Immediate Cause (Final disease a. Hypertensive Atherosclerotic Cardiovascular Disease			Between Onset and Death
Examiner	-	or condition resulting in death)  Due to (or as a consequence of):			
		Sequentially list conditions, b.			
	Ē	if any, leading to immediate Due to (or as a consequence of):  cause. Enter Underlying Cause c.			
E & K	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
3760, ficate be executed g physician and sthe burial - transit	핅	d. UNPENDED AMENDED			
O, e be e: sician sician	ledical	UNPERIORD AMENDED		23d. Date of d	alivary
876 ufficate	≥	23b. If FEMALE.		Month Month	Day Year
Sox 687 leath certifi e attending for use as t	sician	Pregnant at time of death 5 Other (Specify)	- (6	2	
Bo ne dea	Phys	1 Yes 2 No 9 Unknown 9 Unknown	Did toba	accoluse contribu	ute to the cause of death?
b.O. that the	by F	Fart II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Human immunodeficiency virus, Hyperlipidemia			Probably 4 Unknown
ls, F quires en sig	te d	Triuman inimianodentois virus, riypempidenta	. Was an		ere autopsy findings available
orc law re has be 2 sho	ompleted	릴	autopsy performe	ed? de	or to completion of cause of ath?
Rec The ficate	힝		Yes 2	<b>✓</b> No 1	Yes 2 No
ician:	å	25. Was case referred to medical examiner?   Hospital: 4   1   1   2		esidence 6 🗸	Other Scene
Phys Phys eral di	£	1 V Yes 2 No 28b Time of Injury 28c Injury 28c Injury 28c Injury 28d De		w injury occurred	
nding th.	io io	1 Natural 5 Pending (Month, Day,Year)			
iSic r Atte er dea irecto	ficat	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.			or Rural Route Number, City
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Division of Vital Records, P.O. Box 687. To the Hospital or Attending Physician: The law requires that the death certiff within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	cal C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the lone one 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time	ne cause(	s) and manner a	es stated.
To th withir To th	edical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time and manner stated,  29b. Signature and title of certifier  29c. License number			(Month, Day, Year)
	Σ	29b. Signature and title of certifier  29c. License number  O.C.M.E.		October 25,	
1	ļ				
Con )		30. Name and address of person who completed cause of death (Item 23a)  Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2120	01		
S	ate	32. Registrar's Signature			
Regis					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 29 Month Year **Physician** 21:50 PM Catherine Hauf October 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Franklin Square Hospital Center Rosedale Baltimore 8. Date of Birth (Month, Day If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 F Director 217 22 3632 83 10/21/1927 West Virginia Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner intest to indiffed at another. Director 1 □Yes 2 □ No Maryland | Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 431 S. Taylor Avenue 21221 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐Yes 2 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by White 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ferman Haines Pauline Catherine 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martin Hauf (husband) 431 S. Taylor Avenue Essex Maryland 21221 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cem 11/2/2010 Baltimore County, Md 4 ☐ onation 5 ☐ Other (Specify) 21. Signatur 22. Name and Address of Facility Bruzdzinski Funeral Home PA or Funeral Service Licensee 1407 Old Eastern Avenue Essex Maryland 21221 23a. Par 11. Enter the disease, or or mplical earliers, which rheart failure. List only one cause immediate Course (Final disease or or ndition that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death one cause on each line. **Physician** obstruc /Medical resulting in death) Due to (or as a consequence of): Examiner RUMOMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical signed by the attending r IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐Yes 2 ☐No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☑npatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To After this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after deatl To the Funeral Director: 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

0

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

**407 0 1 2010** 

John Kottarathil, M.D.

We Hantil

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

9000 Franklin Square Drive Baltimore, MD 31237

29d. Date signed (Month, Day, Year)

OCTOBER, 29,2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 October 11:20A M Hutton, Jr. Lynn Ray Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Westminster 3502 Old Hanover Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 🛛 M 2 🗆 F Year) Director Yrs. 48 220-80-8109 1961 Pennsylvania Nov. 14. Usual Residence of Decedent 28a-f show a 10b. County filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 🗌 Yes 2 🏻 No Maryland Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3502 Old Hanover Rd. U.S.A. 21158 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify Completed 3 Divorced Year or Dates White 16a. Decedent's Usual Dccupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry 1 and 2 should be filed within 72 Pof Health and Mental Hygiene. Fitem 27 is marked other than "nother traumatic event, the Medi (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 building contractor construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ္ Margaret Blacksten Lynn R. Hutton Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. Lynn R. Hutton Sr./ father 3502 Old Hanover Rd. Westminster, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) All County Cremation 11/1/2010 Sykesville, MD 21. Signatule of Funeral Service Licen 22. Name and Address of Facility Hartzler Funeral Home attarine New Windsor, MD 21776 310 Church St. 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence or): physician and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 2 No the 9 Unknown 9 Unknown ģ s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Abude 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performed? Yes 2 X No this certificate 2 X NO 1 🗌 Yes 25. Was case referred to medical examiner? the funeral director, Be 26. Place of Death (Check only one) Hospital: 2 No Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred After Natural 5 Pending 1 Yes 2 No 2 Accident after death Director: / Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined To the Hospital or within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20 answeiga 30. Name and address of person who completed cause of death (Item 23a) (Type, Plint) Westmins ANSURIYA Malwim 349 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Steven Ross H	ami	4 5 Chit	ment of Health a	re All Copies Are nd Mental Hygiene	Legibl	le.
- BI -		Registrar	icate of Death		Reg. No	<u>. 2010</u> 3411
Physic Medical Exam		<u>Steven</u> Ross Hamilton, Jr.			Day er 25, 20	010 0920 nrs
		4a. Facility Name (if not institution, give street and number) 947 Thompson Blvd	4b. City, Town, 6	or Location of Death		lc. County of Death Baltimore County
Funeral Director		5. Social Security Number 6. Sex 7. Age (in yrs. last b  214-98-5419 1XM 2 F 31  Usual Residence of Decedent	oirthday) If Under 1 Ye  Months Da  Yrs.	um Umum I Min	of Birth (MM 8 – 19	9. Birthplace (State or Foreign Country) MD
Aaryland 28a-f show any 1 at once,	tor	MD Baltimore 10c. City, Tow Baltimore Essex	vn or Location			10d. Inside City Limit 1 X Yes 2 N
ith the Maryland 23a or 28a-f sho notified at once,	I Director	947 Thompson Blvd.	10f. Zip Code 21 221		US	tizen of What Country?
r death w or items	Funeral	11. Marital Status  1 XNever Married 2 Married 12. Was Decedent Ever in U.S.  Armed Forces?  1X Yes 2 No  3 Widowed 4 Divorced If Yes, Give Year 2 0 0 0	If Yes, specify Cuba	lispanic Origin? (Specify Yes can, Mexican, Puerto Rican, etc.	or No- )	14. Race - American Indian, Black, White, etc.
urs aft tural" amine	l by	or Dates:	1 Yes 2 X N	o specify: ation (Give kind of work done	Tack	Specify: White
b, MD 21215-0036 and 2 should be filed within 72 hours after teath and Mental Hygiene. teath and Mental Hygiene. tream 27 is marked other than "natural", traumatic event, the Medical Examiner.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working lif	e. DO NOT use retired)  Mechanic		Kind of Business/Industry  Navy
5-00 ed wit ygien offer he Me	Con	17. Father's Name (First, Middle, Last)	910001	18.Mother's Name (First, Midd		-
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	Steven R. Hamilton, Sr.		Karen Rose	,	· oarianoj
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 77 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical	5			et and Number or Rural Route		
, MD and 2 sho calth and em 27 is		Karen Lang – Mother  20a. Method of Disposition  120b. Place	947 Thomps	on Blvd., Es		
Baltimore, permit. Pages I at Department of Hee Important: If ite	١.	1 Burial 2 Cremation 3 Removal from State crema	e of Disposition (Name of co atory or other place)			Location - City or Town, State
fimit Page retaint:		The state of the s		-		len Burnie, MD
Balt permit. Depart Import injury		21. Signature of Funeral Service Licensee	22. Name and Addres	Draure	y-Asl	hton Funeral
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do r	HOME, PA	such as cardiac or respirator	OW S	pring Road, 212 ock, or heart Approximate Interva
/Medical				cating Asthma	,	Between Onset and Death
xammer		or condition resulting in death)  Due to (or as a consequence of):				
	7	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	miner	if any, leading to immediate out of the cause. Enter Underlying Cause (Disease or injury that initiated out of the cause o				
ecuted and transit	Exal	events resulting in death) Last Due to (or as a consequence of):				
al an	cal	M UNPENDED AMENDED 27				
~ 0 .9.E	Ned	AMENDED 23a, 27, per M  FFEMALE: 23c. If yes, outcome of pregnancy	E G911 1/11/	11 MAM		
Box 68760, seath certificate be the attending physicial for use as the buring of the puring the pur	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3	Ectopic pregnancy	230	d. Date of delivery Month Day Year
Box ie death the atte	hysic	1 Yes 2 No 9 Unknown	5 Other (Specify)			
Vital Records, P.O. B hysteian: The law requires that the d this certificate has been signed by the I director, page 2 should be detached	by P	Part II. Other significant conditions contributing to death but not resulting	ng in the underlying cause	given in Part I. 23e. D		use contribute to the cause of death?
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aw reanas be	Completed				topsy	24b. Were autopsy findings available prior to completion of cause of
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ital ician: certif	Be.	25. Was case referred to medical examiner?  Hospital: Inpatient 2 FR/0		e of Death (Check only one)		
n of V ding Phys	의	Yes 2 No	Outpatient 3 DOA  Time of Injury 28c. Inju	Other Nursing Home 5		nce 6 Other: Scene
Division of Vital Records, tat or Attending Physician: The law require is after death.  al Director: After this certificate has been sided in by the funeral director, page 2 should be	ertification:	1 X Natural 5 Pending (Month, Day, Year) 2 Accident Investigation	1	Yes 2 No	be now inju	iry occurred
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director.	() F	3 Suicide 6 Could not be determined (Specify)		or Town	n, State)	nd Number or Rural Route Number, City
To the Howithin 24 To the Fu	edica	(Check only   Certarying Physician: 1o the best of my knowledge, de. one) 2 Medical Examiner: On the basis of examination and/or i and manner stated.	investigation, in my opinion	, death occurred at the time, da	ause(s) and	d manner as stated. ce, and due to the cause(s)
	≥	29b. Signature and title of certifier	29c. Licens			Date signed (Month, Day, Year)
		Janua Vilhall, MD	O.C.I	VI. ⊑.	Octo	ober 26, 2010
+1		10. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examine	r 111 Penn Street	t, Baltimore, MD 21201		
Sta	te	11. Date filed (Month, Day, Year) 32, Registrar's Signature	om ouco	.,		

DHMH 17 Rev 1/2001 OCME 2006

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			State of Ma	aryland / Depa	rtment of H	lealth and N	lental Hygie	ne			
			1 - State Registrar	Cer	tificate of	Death	Reg.	MS 0   0	34145		
	Physici	an	1. Decedent's Name (First, Middle, Last)	L-1-11			Date of Death     Month	Day Year	3. Time of Death		
E	/Medic		I Nema G	- 1501 10	ra		10 3	11.35 PM.			
è	Examir	er	4a. Facility Name (If not institution, give street and number)			r Location of Death		4c. County of Deat Baltim			
÷	Funeral		Genesis-Cromwell Center  5. Social Security Number   6. Sex   7. Age	e (In yrs. last birthday)	If Under 1 Year	timore  If Under 24 Hrs.	8. Date of Birth	9 Birt	hplace (State or Foreign		
	Director		230-05-3851	89 Yrs.	Months Days	Hours Min.	Ocy. 15,	ar) Co	<sup>untry)</sup> rginia		
	pu. »		Usual Residence of Decedent	10c. City, Town or Loc	nation						
	faryla shov	or						10d. Inside City Limits 1 ☐ Yes 2 🕱 No			
	the N 28a-1 notifi	Director	Maryland Baltimore  10e. Street and Number	TOW	7SON 10f. Zip Code		10a.	Citizen of What Co			
	3a or		1302 Providence Road			286		U.S.A			
	deat	Funeral	11. Marital Status  12. Was Decedent B Armed Forces?	ever in U.S. 13. V		dispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - Ame Black, White	rican Indian,		
36	or its	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ Never Married 2 ☐ Married 1 ☐ Yes Give	10	☐ Yes 2X No	Specify:	1110411, 010./	Specify:	s, etc.		
2-003	hour tural		3 Widowed 4 Divorced Year or Dates:  15. Decedent's Education	16a Deced	ent's Usual Occup	nation	164	. Kind of Business/	White		
5	in 72  n "na Medic	plet	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5	(Give I	kind of work done OO NOT use retired	during most of work d)	ring	Private Duty			
212	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the Medical Examiner must be notified at	Be Completed	2		Nurse		]	Nursing C	are		
g	uld be filed within 72 hours after death with the Marylan Aenda Hygiene. Ked other than "natural", or Items 23a or 28a-f show tic event, the Medical Examiner must be notified at	Be (	17. Father's Name (First, Middle, Last)	18. Mother's Name			e (First, Middle, Mai	den Surname)			
Maryland	should and Men marke	은	Jasper William H	re Virgi	e						
<u>a</u>	d 2 T is		19a. Informant's Name/Relationship (Type. Print)  Jim Holford Son	1	g Address (Street Providen		Tourson	ty or Town, State, 2 Maryland			
<u>ق</u>	s 1 and if Health item 27 other tr		Jim Holford Son  20a. Method of Disposition	20b. Place of Dispos	sition (Name of	i		Location - City or			
altimore,	(h) () h		1   Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	Dulaney Memoria	Valley 1 Garden	c : 11_2	-2010 T	imonium	Maryland		
<u>=</u>	permit. Page Department Important: If any Injury or once.		21. Signature of Funeral Service Litensee		. Name and Addre				Home, Inc.		
<u>n</u>	9 3 5 6		taul W Hagan		1050 Yo	rk Road	Towson, I	Maryland	21204		
			23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin	the death. Do not ente	er the mode of dyir	ng, such as cardiac	or respiratory arrest,	,	Approximate Interval Between Onset and Death		
Ÿ	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	ere ao	tvana	of Co	racomy	pally			
•	Examiner		COC	a consequence of):	in	dan	en &	1 1	,		
и	π ₩	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a consequence of):	- / W C						
	be executed ician and burial-transit	Examiner	that initiated events  c.	V							
90	9 2 9	I — I	Due to (or as a	a consequence of):							
68/60	death certificate be a attending physicie d for use as the bu	Physician/Medica	d								
ROX	n certii anding use a	n/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome		1			23d. Date of del	ivery		
	0 0	sicia	in the past 12 months?		Ectopic pregnanc <sub> </sub>  Other <i>(specify)</i> _	y 		Month	Day Year		
J.	at the 1 by th stache	Phys	9 Unknown								
Ś	law requires that the de as been signed by the 2 should be detached	þ	Part II. Other significant conditions contributing to death but	it not resulting in the un	iderlying cause giv	en in Part I.			the cause of death?		
ecords,	requ	eted					1 Tyes				
ĕ	sician: The law certificate has b irector, page 2 s	Completed					24a. Was an autopsy performed	prior to	itopsy findings available completion of cause of		
_	an: T tificate or, pa	င်	25. Was case referred to medical			26 Place of Deni			2 No		
	Physician: this certific ral director,	o B	examiner?	nt 2 ☐ ER/Outpatient	t 3 DOA Oth		ome 5 Residenc	e 6 ∏Other /Sne	cify)		
	ding Physin.  After this of funeral directions.	n: T	27. Manner of Death 28a. Date of Injur		28c. Injui Wor	ry at	28d. Describe how	njury occurred	,		
<u> </u>	Attending or death. rector: After by the funer	catic	2 Accident investigation			Yes 2 □ No					
DIVISION	or Atten after death Director: in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of inju- building, etc	rry - At home, farm, stre c. <i>(Specify)</i>	eet, factory, office		28f. Location (Stree City or Town, S		ural Route Number,		
_	spital ours a neral I		29a. Certifier 1 Certifying Physician: To the best of	of my knowledge, death	occurred at the ti	me, date and place	and due to the caus	e(s) and manner a	stated		
	To the Hospital or At within 24 hours after of To the Funeral Direc completely filled in by	Medical	(Check only 2 ☐ Medical Examiner: On the basis of one) and manner sta	examination and/or invited.	estigation, in my	opinion, death occu	rred at the time, date	and place, and due	e to the cause(s)		
	To the company of the	M	29b. Signature and title of certifies Molling	MO	29c. Licens	se number	29d.	Date signed (Mont	h, Day, Year)		
			P/ 1/01/01/01/01/01/01/01/01/01/01/01/01/01	ー・リン	103	575	10	-25-4	J.		
			30. Name and address of berson who completed cause of de	eath (Item 23a) (Type, F	Print)	ne fe	16 208	Im	30140-		
(to	Sta	te	31. Date filed (Month, Day Year) 32. Registry	Signatur			7-1	, ,	n, Day, Year)  Son "D2/2cd		
	Registr		31. Date filed (Month, Day Year)								

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Jonathon Dion Ja		on (	State of Maryl		rtment of tificate of		d Mental		201	0 34146	
Physicia	5/ 10/	Registrar  1. Decedent's Name (First, Mi	ddle,Last) Jona	than Dio	n Jacks	on_		2. Date of Dea		3. Time of Death	
Medical Examir	-	20111911	100	O. 1	*				er 28, 2010	1827 hrs	
1		4a. Facility Name (if not institu Prince Georges Hos	ution, give street and n	umber)	4	b. City, Town, or Cheverly	Location of De	eath	4c. County of Death Prince George's		
Funeral	4	5. Social Security Number	6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Yea	r If Under 24	Hrs. 8. Date of Bi	ith(MM/DD/YYYY) 9. I	Birthplace (State or	
Director		439-89-9541	1 M 2 F	15	Yrs.	Months Day	Hours I	Min. 12-0	1-1994	eign New Octeurs, Country) LA.	
		Usual Residence of Decedent		Idon Cibi	Town or Location					10d. Inside City Limits	
ow any		10a. State 10b. Coun	C				CTN	.)		1 ZYes 2 No	
ryland ra-f sh	향	10e. Street and Number	<i>G</i> ,	10	K I VV	ASHIN 10f. Zip Code	16 70		10g. Citizen of What C	ountry?	
ith the Maryland 23a or 28a-f show notified at once.	Director	8601 Joli	ly Lone			20:	144		USA		
n with ms 23.	eral	11. Marital Status 1 X Never Married 2	3	ecedent Ever in U. Forces?		Decedent of His		( Specify Yes or N erto Rican, etc.)	o- 14. Race - Am White, etc	nerican Indian, Black,	
er deatl	Ē	,	1 Yes Divorced If Yes, Give Y	2 🗶 No	1	Yes 2 X No	specify:		Specify:	lack	
urs aft 	e e	15. Decedent's Eoucation (S	or Dates:		16a. Decedent	's Usual Occupa est of working life	tion (Give kind		16b. Kind of Busines	ss/Industry	
6 172 ho an "na ical Ex	ete	Elementary/Secondary (0-1	(12) College	(1-4 or 5+)		uden T		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	nla		
within giene.	Completed	1074 17. Father's Name (First, Mid	dle Last)		57	u veri 7	18.Mother's N	ame (First, Middle,	Maiden Surname)		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	BeC	TOSEPH	-	2R					TACKSON		
		19a. Informant's Name/Relati		Month		Address (Street)	et and Number	or Rural Route Nu	Imber, City or Town, St	ate, Zip Code)	
MD 2 sho salth and 2 set of 1 is raumati		JESSIE (20a. Method of Disposition	JACKSOI	20b. 1	Place of Disposi	tion (Name of ce		Date	20c. Location - City		
Baltimore, permit. Pages I an Department of He. Important: If ite		1 Burial 2 Crema			crematory or oth		netery 1	olistio	Kenner	LA	
Baltimore permit. Pages I Department of I Important: If		4 Donation 5 Other 21 Signature of Funeral Serv		[[10		ame and Addres		. 11	420 H	STIPE	
Balt permit. Departr Import injury		Lisa a. K	denny r	MOINS		10 K-14		ineval 19	ome wasit	Approximate Interval	
Physician / /Medical		23a. Part I. Enter the disease failure. List only one car	use on each line.		. Do not enter tr	ne mode of dying	such as cardi	ac or respiratory a	rest, shook, or heart	Between Onset and Death	
Examiner		Immediate Cause (Final dise or condition resulting in deat	ase a. Multiple II  Due to (or as	njuries s a consequence o	of):						
		Sequentially list conditions,	b								
	iner	if any, leading to immediate cause. Enter Underlying Cau	use	s a consequence o	f):						
sit d	Examiner	(Disease or injury that initiate events resulting in death) La	Due to (or as	a consequence o	of):						
executed ian and ial - transit	dical E	UNPENDED	d.  AMENDE	IperME,     per ME g	G909,11	/12/2010	,WS				
60, ate be ohysicia	Med	IF FEMALE:	23c. If ye	s, outcome of preg	nancy	3/10 11			23d. Date of deli		
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be hin 24 Hours after death. The law requires that the death certificate be the Purenzal Directora. After this certificate has been signed by the attending physici in pletely filled in by the funeral director, page 2 should be detached for use as the buring	sician/Me	23b. Was decedent pregnant past 12 months?	, C	e birth gnant at time of de	noth -	tal death 3 her (Specify)	Ectopic pre	egnancy	Month	Day Year	
BOX death he atter	Physic	1 Yes 2 No 9	- [	known				1 == = :.		to the course of death?	
bat the ed by t	by Pt	Part II. Other significant co	nditions contributing	to death but not r	esulting in the u	ınderlying cause	given in Part I.			e to the cause of death?  Probably 4 Unknown	
IS, P quires t en sign ald be o	ted k							24a. Wa	s an 24b. Were	autopsy findings available	
Cord law rec has bee	Completed							per	formed? death		
Rec : The ificate r, page		25. Was case referred to me	dical			26.Plac	e of Death (Ch	1 Yes	2 No 1 🗸	res 2 No	
/ital ysiclan his cert directo	o Be	examiner? 1 Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatient	3 DOA	Other <sub>4</sub> N	ursing Home 5		ther:	
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detach	<b>—</b>	27. Manner of Death	Sa <sup>(Mg</sup>	nte of Injury Inth, Day, Year) 8, 2010	28b. Time of I	´ ´	ury at Work? Yes 2 ✔ No	Motorcycli	e how injury occurred st struck mailbox	and tree	
Sion Attend death.	Certification:		Investigation	lace of Injury - At h					(Street and Number of	r Rural Route Number, City	
Divis	rtifi		Could not be	(y) Major Roa				or Town			
Hospit 24 hour Funer tely fil		29a. Certifier	ng Physician: To the l	best of my knowled	dge, death occur	rred at the time,	late and place	and due to the ca	use(s) and manner as	stated.	
To the within To the comple	Medical		and manne	is of examination a er stated.	and/or investiga		n, death occur se number	red at the time, da	te and place, and due t		
	Σ	29b/ Signature and title of ce	eruner .			1	.M.E.		September 29		
		30. No me and address of pe	eson who completed o	ause of death (Iten	n 23a)						
		Laron Locke MD.	Assistant Medi			Street, Balt	imore, MD	21201		in the second	
	tate	0.14931		Redistrar's Signat	ture .	arked					
Regis	116	MILLA	MITTOIN	No.	1 1						

DHMH 17 Rev 1/2001 OCME 2006

OCME

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day $P^{M}$ 2010 9:39 0ct Melvin Stephen Jacobs 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Montgomery Silver Spring Holy Cross Hospital If Under 24 Hr Hours Mir 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign Months 1 💢 M 2 🗆 F 10-02-1939 New York Yrs 100-30-7195 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Tes 2 X No Beltsville Prince George's MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe United States 3909 Lakehouse Road #6 20705 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 X Yes 2 No 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 X Divorced White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Travel Vice President 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph M. Jacobs Bella Friedman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryland 21035 Karen Dunlap / Friend 2746 Swann Way Davidsonville, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🔲 Burial 2 💢 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) Arundel Crematory 11-01-2010 | Odenton, Maryland <sup>22</sup> Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113 Signature Funeral Service Lens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory Distress - Possible PE day disease or condition resulting in death) Due to (or as a consequence of) Cardiac Stents Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Acute Inferior Wall MI 19 days Due to (or as a consequence of): Rt Coronary Artery C Diffuse Thrombus 100% Proximal Stenosis Evident 19 Days 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month Dav 5 Other (specify) Pregnant at time of death

Physician/ Medical Examiner

Physician/

Medical

Director

Funeral

δ

Completed

Be

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Examine

Physician/Medical

Completed by

Be

Certificate: To

Medical

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Sanguetta ?

<u>Sangeetha Ranganath,</u>

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signature

Examiner

**Funeral** 

Director

ral", or items 23a or 28a-f sho Examiner must be notified at

"natural", or

ntal Hygiene.

ced other than "natur.
cevent, the Medical E

Ith and Mental H 27 is marked or traumatic ever

Department of Health ar Important: If item 27 is any injury or other trau

Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-transit certificate has been signed by the atte irector, page 2 should be detached for ieral Director: A filled in by the fu

To the Hospital or Attending Physician: The law requires that the death certificate be executed

this

After t

within 24 hours a

To the Funeral C

completed filled

Division of Vital Records, P.O. Box 68760

Cause (Disease or iinjury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DM, Afib, AMI, Hemolytic Anemia, BPH, CAD, Migraines, 1 ☐ Yes 2 👿 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Spleenomegaly autopsy performed? Yes 2X No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛛 No 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

10/27/2010

29c. License numbe

D69835

1500 Forest Glen Road Silver Spring, Maryland 20910

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 932 DM borah Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 5. Social Security Number 215–68–2592 7. Age (In yrs. last birthday) 8. Date of Birth 9 Birthplace (State or Foreign **Funeral** 1 □ M 2 X F Months Hours Min (Month, Day, Director MD Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Essex 1 Yes 2 X No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 555 S. Marlyn Avenue 21221 USA 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 XNever Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Quality Control Inspector 2yrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Geraldine Gordon Harry Jacob permit. Page 1 and 2 should be Department of Health and Ment Important; If item 27 is marke any injury or other traumatic. once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Geraldine E. Jacob/mother P.O.Box 1481 Solomons, MD 20688 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗆 Burial 2 🕱 Cremation 3 🗆 Removal from State Bayview Crematory 10/29/10 Baltimore MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 🗙 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 X No 1 ☐ Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 296 License number MT7 4546 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fitzacrald Baltimore Karıma 225 Greens 31. Date filed (Month, Day, Year) State **MOV 0 1 2010** Registrar

Amend #8 State of Maryland 1068 at the Moof Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 6:25A Month **Physician** 20 /Medical Eacility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore aver 7. Age (In yrs. last birthday) mi atonsul If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** -26-125 Months 1 □ M 2 1 F Director 03-25-1929 Usuat Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f show other traumatic evant, the Medical Examiner must be notified at 1 Nes 2 No Director Baltimore MD atonsvill 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö Rd 21228 or Items 23a 1308 lanuilde Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼No 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or lier any injury or other traumatic event 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: If Yes, Give Year or Dates: Specify: Completed by 3 Widowed 4 □ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Sewing 9 # Scamstress Grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Stringfield Josephina John Wright 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Octavia Rector Grandoloughter 308 Gland de Ra.

20a. Method of Disposition

1 Method of Disposition 3 Removal from State

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date Catonsville, MD 21228 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Vastern Star Com. 11-05-2010 Baltimore, MI
22. Name and Address of Facility Murray + Tellington Funeral 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee Menny Mary Home /4804 Georgia Ave., NW/Wash., DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician NEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine use as the burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 the attending physician The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4 Pregnant at time of death detached signed by the 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 1 ☐ Yes 2:2 No 26. Place of Death (Check only one) 25. Was case referred to medical funeral director, examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 9 Hospitel or Attending Pl 24 hours after death. 9 Funaral Diractor: After th Certification: 5 Pending Natural 1 🗌 Yes 2 🗌 No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel c within 24 hours at To the Funeral Di 29a. Certifier Fortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Dav. Year) 29b. Signatur and title of certifier 29c. License number 28595 mu) un 30. Name and address of person, who completed cause of death (Item 23a) (Type, Print) 2835 HIRECE 32. Registrar's 31. Date filed (Month State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Olds siian Ochober Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number, Examiner N/A Johns HO PunsBayure Medual Center Baltimore g. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, Sept. 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs, last birthday, 6. Sex **Funeral** Days Min. Months Hours 1 □ M 2 🖾 F Sept. 195 213-64-8671 57 Director Usual Residence of Decedent 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 10c. City. Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10a. State Director 1 ☐ Yes 2 🏝 No MD Baltimore Dundalk 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 2920 Yorkway 21222 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo 14. Race - American Indian 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 Yes 2 XNo Specify: If Yes, Give Year or Dates White 3 Widowed 4X Divorced permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Years Years Student Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Claude A. Julian Carrie Mae Harrison 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2920 Yorkway Dundalk, Maryland Tammy McCone (Daughter) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🗌 Burial 2 🔄 Cremation 3 🗌 Removal from State Hilltop Service Corp. 10/27/2010 Towson, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk,
7022 Wise Ave. Dundalk, Maryland . Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between t and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical inhauascular coaquator Examiner Disseminated Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last 12hrs Physician/Medical P.O. Box 68760 MPROTED M MEDICAL IF FFMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) Pregnant at time of death Yes 2 No CERTIFICATION 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 XINo 26. Place of Death (Check only one) 25. Was case referred to medical **Division of Vital** Be examiner? 1 X Yes Other: 2 1 No Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28d. Describe how injury occurred 27. Manner of Death Certificate: 6:30AM ☐ Natural 5 Pending nouse 10,24,2010 2 X No 1 Tes 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, Town, State) within 24 hours after

To the Funeral Directory

completed filled in b 2920 Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 7169 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EASTERN AVE BALTIMORE, MD 21224

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

**NOV 0 1 2010** 

4940

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Vivian Lynette Keith 2-26PM 010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan Hospital Baltimore If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) 10-5-1930 Min. Days Hours Country) Director 208-24-8299 80 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2X No MD Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò event, the Medical Examiner must be 21234 Funeral USA 23a 1612 Lyle Court with Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12, Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. ō 2 XNo þ 1 Never Married 2 Married ☐ Yes land 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: Black "natural", 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry Un ... (Specify only highest grade completed) than " Elementary/Seconday (0-12) College (1-4 or 5+) Hygiene. permit. Page 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other this any injury or other traumatic event, the 1 one. Various 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Felton Keith Rose Fant Baltimore, Maryl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Parkville, Md 21234 Richard Keith- Son 1612 Lyle Ct 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 10-29-10 Baltimore, MD 4 Donation 5 Other (Specify) Greenmount East F/H March 21. Signature of Fuperal Service Licensee 22. Name and Address of Facility 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year 5 Other (specify) Pregnant at time of death ed by the a g 🗌 Unknown g | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed b Completed by 2 No Division of Vital Records, 1 Yes 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: The thin 24 hours after death. certificate 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral ( 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 Natural 5 Pending work? 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 🖰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number MEDICAL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SUTH ITRA PARANTI, 5601 LOCH RAVEN BLVD, BACTIMORE, MD-21239

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11/1/2010, WS State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 20 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OCTOBER 12, 2010 Physician/ Richard Carl Koch 0650 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Casey House Rockville Montgomery 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 🕅 M 2 🗆 F AUG 10, Year) 80 027-26-4308 Director Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2X No MD Silver Spring Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20906 3330 N. Leisure World Boulevard #501 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 X No Specify: Yes. Give Korean 3 X Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. I other than " Pfizer College (1-4 or 5+) Elementary/Seconday (0-12) Pfiser Research Chemist / Advisor Be 18. Mother's Name (First, Middle, Maiden Simme SS 17. Father's Name (First, Middle, Last) and Mental t ၉ permit. Page 1 and 2 should be Department of Heath and Ment. Important if item 27 is marked any injury or other from Karl Robert Koch Henrietta Bauchhens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth C. Koch / Daughter 2950 McKinley St., NW, Washington, DC 20016 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 15<sup>Date</sup> cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Atlantic Crematory  $10/\frac{12}{2010}$ Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furieral Service Licensee 22. Name and Address of Facility Thibadeau Mortuary Service, 7 Park Avenue, Gaithersburg 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final h sician/ CEREBROVASCULAR ACCIDENT disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and led by the attending physician and detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Unknown ate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 ☐ Probably 4 Thknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed?

1 Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6 X Other (Specify) 1 🔲 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred 1 X Natural iniury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation the f 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number 10+ OCTOBER 12, 2010 R143201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 MUNCASTER MILL ROAD, ROCKVILLE, MD 20853 DEBORAH MILLER, CRNP, 31. Date filed (Month, Day, Year) State OCT 15 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month i O Year Physician/ 2010 Oven Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Baltino RAVEN CLC 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number Days **Funeral** (Month, Day, 215-52-2333 60 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f shov 10a. State 10b County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 Yes 2 No MD timore 10g. Citizen of What Country? 10e. Street and Num Completed by Funeral Page 1 and 2 should be filed within 72 hours after death with 1 ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a ury or other traumatic event, the Medical Examiner must by vania 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married 1 🗌 Yes 2 No Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT yearetired) College (1-4 or 5+) ay (0-12) Be 18. Mother's Name (First, Middle, Mai မ 19b. Mailing Agaress (Street and Number or Rural Route Number, City Department of Health Important: If item 27 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) any injury 21. Signature of Funeral Service 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or hear failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final Talignent Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examiner signed by the attending physician and doetached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ Year Month Day in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Unknown should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 M No 3 ☐ Probably 4 ☐ Unknown Mellitus 24b. Were autopsy findings available prior to completion of cause of death? stic liver cir/ho/i/ 24a. Was an autopsy performed? has 2 🗷 No page 1 Tyes the Hospital or Attending Physician: The 26. Place of Death (Check only one) 25 Was case referred to medical Division of Vital Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) examiner? Hospital 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ြို 28d. Describe how injury occurred 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: To the musping within 24 hours after death.

To the Funeral Director: After the funeral by the f 5 ☐ Pending \_\_Investigation 1 🔼 Natural 2 Accident
3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Could not be 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

Loch Raven Blud

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mnowiec

31. Date filed (Month, Day, Year)

3900

. Registrar's Signa

047804

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Reg. No. 2 1. Decedent's Name (First Middle | ast) 2. Date of Death 3. Time of Death Day Physician/ Month Year PM NIR 331 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner MVersity Mare 5. Social Security Number If Under 24 Hrs 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) Funeral Days Hours Min 1 ☐ M 2 ☐**X**F Months Yrs. Director 224-40-7581 75 n /1935 Usual Residence of Decedent iral", or items 23a or 28a-f sho Examiner must be notified at 28a-f shor 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits death with the Maryland Director 1 Yes 2 No MD Derwood Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20855 16720 Baederwood Lane \_ A 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Year or Dates. 3altimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2X No Specify: White Specify: 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Emmanuel Hnarakis Vasiliki Gianakakis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16720 Baederwood Ln., Esher R. Kweller (Husband) Derwood, MD 20855 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1

✓ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/6/10 4 ☐ Donation 5 ☐ Other (Specify) Appomattox Cem. Hopewell, VA 22. Name and Address of Facility Service Licensee 820 W. Broadway Av. Timothy Harman J.T. Son F.H. Hopewell, Morriss 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Infarction Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or se a consequence or, To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) in the past 12 months? Ectopic pregnancy Month Day Year Pregnant at time of death signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been signated by page 2 should b . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? certificate 2 🔽 1 Tyes 2 No Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 NO 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this of completed filled in by the funeral directions. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 🗌 Yes 2  $\square$  No Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier AU4176435K1975 10/29

Registrar
DHMH 17 Rev 7/2009

State

Zachar

31. Date filed (Month, Day, Year)

Greene

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 29 Month OCTOBEK Physician/ 08:45AM Thomas Kelly, III 2010 Leo Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE TOWSON CENTER SAINT JOSEPH MEDICAL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 🛛 M 2 🗆 F Months Days Hours Min. Sept. 4 Maryland 79 Director 216-28-1465 1931 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 X No Baltimore Timonium Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 12240 Roundwood Rd. #104 21093 USA Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. Yes 2 X No Yes, Give þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White "natural" Completed Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Sales Manager Home Improvement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Thomas Kelly, Jr. Margaret Clay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Health tem 27 12240 Roundwood Rd. #104 Timonium, Md. 21093 Mrs. Eleanor Kelly/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley Mem. 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a Department of I-Important; If ite any Injury or ot 1 X Burial 2 Cremation 3 Removal from State 11-2-10 Timonium, Md. 4 ☐ Donation 5 ☐ Other (Specify) <sup>22. Name and Address of Facility</sup> RUCK Towson Funeral Home, 1050 York Rd. Towson, Md. 21. Signature of Funeral Ser ice Ligensee 23a. Part 1. Enter the disease, or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fall i.e. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LEUKEMIA Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Due to (or as a consequence oi). in any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Pregnant at time of death g Unknown Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has e 2 page certificate 1 Yes 2 No Yes **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 XNo မြ 1 🗌 Yes 1 Nnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours I fler users.

To the Funeral Director: After the 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide (Month, Day, Year) injury 5 Pendina 1 ☐ Yes 2 ☐ No. Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner, To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature a 29d. Date sig D 36814 Type, Print) 30. Name and address of person who completed cause of death (tem 23a)

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State Registrar 32. Registra s Signa dre

OSLER DRIVE

TOWSON

21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #30 Per DVR G909 II/01/10 JH
State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	State of Maryla	•	tificate of E		iria ivien	_	glerie Reg. No. 🤈	2010	31.156
ı	Physicia	n/	Decedent's Name (First, Middle, Last)	Paul Pete	er Ka	aputsos		1	ate of Dea	Day	Year	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give s		- 10	4b. City, Town, or	Location of		ct	20 <b>,</b>	2010 ounty of Death	3:55 P <sup>M</sup>
	/		307 South Robinso	on Street		Balti	more	City			N/A	
Ī	Funeral Director		219-10-3298	7. Age (In yrs. 88	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours		ate of Birt Month, Da t • 7	h y, Year) 1922	Cour	place (State or Foreign ntry) EC E
	show at	٥	Usual Residence of Decedent  10a. State 10b. County	10c. C	City, Town or Loc	cation						10d. Inside City Limits
	Maryla 8a-f s tified	Director	MD N/A					Baltim	ore	City		1 ☒ Yes 2 ☐ No
	a or 2 be no		10e. Street and Number			10f. Zip Code				10g. Citize	n of What Cou	ntry?
	th with ms 23 must	Funeral	307 South Robin		10 100		224	i=0.(C= ==if+)	/aa au Na		S.A.	
036	ould be filed within 72 hours after death with the Maryland id Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	2	11. Marital Status  1 ☐ Never Married 2 ☒ Married  3 ☐ Widowed 4 ☐ Divorced	<ul> <li>12. Was Decedent Ever in UArmed Forces?</li> <li>1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.</li> </ul>		Was Decedent of Hi f Yes, specify Cuba ☐ Yes 2 🔀 No		Puerto Rican	es or No- I, etc.)		. Race - Americ Black, White, pecify:	
2-0	2 hour "natu	plet	15. Decedent's Edu (Specify only highest grad		16a. Deced	lent's Usual Occupa kind of work done o	ation during most o	of working		16b. Kind	of Business tn	dustry
121	thin 73 ane. than ne Me	Completed	Elementary/Seconday (0-12)	College (1-4 or 5+)	life. Do	O NOT use retired) Lesman	g			Δ111	tomotiv	0
d 2	led wi Hygie other ent, tl	Be	8 Years  17. Father's Name (First, Middle, Last)			Lesillan	18. Mother	r's Name <i>(Fir</i> s	t, Middle,			
<u>la</u>	d be filed vental Hygurked other	욘	Peter P. Kaputs	sos			S	evaste	Stra	atis		
, Maryland 21215-0036	sh har 7 is trau		19a. Informant's Name/Relationship (Type Mrs. Doris E. Kapı	ng Address (Street a South Ro								
Baltimore,	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 once.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ F  4 ☐ Donation 5 ☐ Other (Specify)	Same access from the Charles	Place of Dispo cemetery, crem eek Ortl	sition (Name of natory or other plac h. Cemete	ery 1	Date 0/25/2	010		tion - City or To	own, State Maryland
Balt	permit. Departn Importa any injt	1 (1	21. Signature of Funeral Service License			Name and Address uda-Ruck 1922 Wise	Ave.	Dunda	a1k,	Mary1		c. 222
23 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresshock, or heart failure. List only one cause on each line.  Immediate Cause (Final								rest,		Approximate Interval Between Onset and Death		
	Physician/ Medical	8 7	disease or condition resulting in death)	Due to (or as a conse	=VD						-	Ondot and Doda
	Examiner			Due to (or as a conse	tom	UDD=	14.					
		iner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying	Due to (or as a conse	quanta oi):	y i	7					
	scuted and transi	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last  C. Due to (or as a consequence of):									
	icate be executed physician and is the burial-transit	calE										
3760	E D 2	Medical I		J								
Box 68	death certi	by Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy  1  Live Birth 2  Fetal death 3  Ectopic pregnancy  4  Pregnant at time of death 5  Other (specify)  Month							d. Date of deliv Month	rery Day Year
s, P.O.			Part II. Other significant conditions cor	tributing to death but not re	esulting in the u	nderlying cause glv	en in Part I.					he cause of death?
Division of Vital Records,	rsician: The law requ s certificate has been lirector, page 2 shoul	Completed							24a. Was autor perfo		prior to co death?	psy findings available empletion of cause of
<u>=</u>	an: The I tificate h tor, page	Be C	25. Was case referred to medical			26. Pla	ace of Death	h (Check only		2 X No	1 🗌 Yes	2 I <b>X</b> No
<u> </u>	hysici nis cer I direc	TO B	examiner? 1  Yes 2 No	ospital: 1			er: 4 🗆 Nur	rsing Home	5 Resid	dence 6	Other (Specify	ν)
וסר	ling Pl	ate:	27. Manner of Death  Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	work	?		Describe h	ow injury o	ccurred	
Sior	Vttend death ctor: A y the f	Certificate	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At I	home, farm, stre		Yes 2 1		ocation (S	Street and N	lumber or Rura	I Route Number,
Š	al or A s after I Direction by		4 L Homicide determined	building, etc. (Spec		,,,			City or Tow			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director.	Medical	(Check 2 Medical Examin	cian: To the best of my kno er: On the basis of examinati Practioner: To the best of	ion and/or invest	tigation, in my opinic	on, death occ	curred at the ti	me, date a	nd place, ar	nd due to the ca	use(s) and manner stated.
	Vithi Voithi Con		29b. Signature and title of certifier	e D 1		29 c. License					signed (Month,	Day, Year)
			P SSTER	Like	21 6		243	53		10 2	2/2010	
/			30. Name and address of person who co	mpleted cause of death (Ite	Y	717	70 Riv	vers Ed	lge R	d. Co	lumbia,	21044
	Stat Registra	e ir	31. Date filed (Month, Day Year)	Server 1	ature and	6						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First Middle | ast) 2 Date of Death Physician/ October 2010 Wanda Marta Kopeck 6:15 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death N/A 3615 Frankford Avenue Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min. 1 🗆 M 2 🕱 F 214-12-4312 91 10 22 2 4 9 1 9 1 9 MarwTänd Director Usual Residence of Decedent show 10a State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director ems 23a or 28a-f sh r must be notified a 1 X Yes 2 No Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21214 USA items 23a Funeral 3615 Frankford Avenue 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner 1 ☐ Yes 2 🕅 No If Yes, Give 9 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: "natural", Completed 3 X Widowed 4 Divorced White Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retiried) HOMEMAKEY 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) the Own Home Be it. Page 1 and 2 should be ... adment of Health and Mental Hy nortant: If item 27 is marked other and their traumatic every 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Przybylowski Victoria Nowakowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Mrs. Charlotte Byrd - Daughter Baltimore, MD 21222 8236 Gray Haven Road Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Parkwood Cemetery 1 XBurial 2 Cremation 3 Removal from State 10-30-2010 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signatur o Funeral Service License 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph\_sician/ CHOLANGIOCARCINOMA ETASTATIC disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequer tially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examine Due to (or as a consequence of): Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Dav Year Pregnant at time of death 2 X No 1 ☐ Yes 2 2 9 ☐ Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed 1 Yes 2 No Yes 2 🗷 No Be ( 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🛣 No Other: မြ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Pleating 24 hours after death.

To the Funeral Director: After the completed filled in by the funeral Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No. Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Nurnber or Rural Route Nurnber, determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 240480 26, 2010 OCTUBER BELAIR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROAD FERRO BALTIMORE FERNANDO 21236 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No?) 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Lingelbach 19:29 PM William October 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Johns Hopkins Bayview Medical Center Baltimore Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral **№** M 2 🗆 F Days Hours April 18, 1953 Country) 57 Director 217-54-4334 M D Usual Residence of Decedent 28a-f shov within 72 hours after death with the Maryland Ħ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Examiner must be notified MD Baltimore 1 🗆 Yes 2 🛶 No 6 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 6505 Pulaski Highway 21237 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Force Black, White, etc ō þ 1 Never Married 2 Married 1 ☐ Yes 2 🗽 No If Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 😾 No Specify: "natural" 3 Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Phoenix TV Repairman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ၉ pe pe William J. Lingelbach Rose Simmons . Page 1 and 2 should be treent of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William J. Lingelbach 18 Judywood Lane Baltimore MD 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date 1 Burial 2 Cremation 3 Removal from State Bayview Crematory 11/1/10 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License 300 Mace Ave. Balto. MD Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that causes the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Hypoxia disease or condition resulting in death) weeks Medical Due to (or as a consequence of): Examiner Pneumonia 3 weeks Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the attended to the control of the con burial-transit Cause (Disease or linjury Squamous Cell Lung Cancer months that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 d. as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Year cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No nours after death.

eral Director: After this certific, filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) 10 2 No 1 Yes Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred ✓ Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Priystoan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

Registrar

State

Jennifer

4940 Eastern Avenue

RES-000

Baltimore,

October 29, 2010

myes & Cumen

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State	State o	f Marylaı		artment of h		and M	lental Hy	/giene	2.0	10	31.150
		Registrar  1. Decedent's Name (First, Middle	- Lost)		Cer	tificate of L	Death		0 Data - ( Da	Reg. N	مکر ل	1 0	J41J2
Physiciar		` '	, ,					. 1	2. Date of De Month		g 20	YP#	3. Time of Death 2:18 A M
Medica Examine		Mary Louise La  4a. Facility Name (if not institution		nber)		4b. City, Town, o	r Location o	of Death	00000	$\overline{}$	c. County o		[2.10 A
ZXumme	•	28 Allegheny A	venue # 80	)5		Towson							County
Funeral		5. Social Security Number	6. Sex 1  M 2  K	7. Age (In yrs.		If Under 1 Year Months Days	If Under Hours		8. Date of Bir	rth	20		place (State or Foreign
Director		215-12-3959 Usual Residence of Decedent	I LI WI Z LIF	90	Yrs.		110010		Sept. 1	6,19	20	Afab	Tama
at at	ō	10a. State 10b. County		10c. C	ity, Town or Lo	cation						1	0d. Inside City Limits
Aaryla 8a-f s tified	rect	Maryland Balti	more	То	wson								1 🗆 Yes 2 🛚 No
the Na or 2	٥	10e. Street and Number				10f. Zip Code				10g. C	itizen of W	hat Coun	try?
th with the Maryland ms 23a or 28a-f show must be notified at	Funeral Director	28 Allegheny A				21204					ted S	State	es
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d with	Be C	17. Father's Name (First, Middle, I	l acti		Art	ist	10 Math	aula Nama	(First, Middle,	<u> </u>	If Em		rea
be file	2	Jessie Johns					l .		aque l	, ivialueli	i Surriairie)		
nd Me s mar		19a. Informant's Name/Relations			19b. Mailir	g Address (Street			•	er, City o	or Town, Sta	ate, Zip C	Code)
d 2 stath a n 27 is er tra		Joseph Lanci			1	1egheny							
of He  of He  if item		20a. Method of Disposition 1   Burial 2   Cremation	3 Pemoval from		Place of Dispo cemetery, cren	sition (Name of natory or other plac	ce)	D	ate	20c. l	_ocation - (	City or To	wn, State
Page tment tant: jury o		4 Donation 5 Other (	Specify)	Hi Hi	11top S	Service C	orp.	Oct.	29,2010	-			ryland
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service I	icensee			. Name and Addre		•	Llomo		50 Yo		
	_	23a. Part 1. Enter the disease, or	complications that c	aused the dea							wson,	mary	Approximate
Ph_sician/		shock, or heart failure. List of Immediate Cause (Final	only one cause on ea	ch line.		404.0	J.		, ,				Interval Between Onset and Death
Medical		disease or condition resulting in death)	a. Due to (	or as consec	ence of):	ma						-	Xeurs
Examiner		Sequentially list conditions,	b. ———	<b>C</b>	22								<i>'</i>
n #	ine	if any, leading to immediate cause. Enter Underlying		or as a consec	quence of):								
and -trans	Examine	Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to 6	or as a consec	ulence of:							-	
ate be executed hysician and the burial-transit	dical E	rosaning in deathy East			,400.000								
icate l	0		d										
certif ending use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregn Birth 2  Fet		Ectopic pregnanc	~V			Į.	23d. Date	e of delive	ery
death	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at time of		Other (specify)	-y				Mon	th	Day Year
at the		9 Unknown  Part II. Other significant condition	ans contributing to de	eath but not re	sulting in the u	nderlying cause di	ven in Part I		220 Did t	labassa	uso contrib	nute to th	e cause of death?
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requi	ete	7/20700		7 <del>1 0 0 10</del> ,					24a. Was			ere autop	sv findings available
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an: The tifficat tor, pa	Be C	25. Was case referred to medical				26. Pl	ace of Deat	th (Check	1	2 🛂 🛚	1 1	☐ Yes	2 ∐ No
ysicia lis cer direc	일	examiner? 1 🗆 Yes 2 🖾 No	Hospital:	Inpatient 2	BR/Outpatien	t 3 DOA Oth	er: 4 🔲 Nu	ırsing Hor	ne 5 D Resi	dence	6 Other	(Specify)	
frer thunder		27. Manner of Death 1 Natural 5 ☐ Pendir	28a. Date of (Mont	of injury h, Day, Year)	28b. Time of injury	28c. Injury	?		8d. Describe I	how inju	ry occurred	t	
ttendi death tor: A	Certificate:	2 Accident Investi	gation not be	of Injune At h	ama farm atu		Yes 2 🗆	_	201 1 1 4			- 0 -/	D. d. M
after after Direction by		4 Homicide determ	nined   26e. Place buildir	ng, etc. (Specif	fy)	eet, factory, office		2	City or Tov			or Hurai	Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical		Physician: To the be										
he Ho in 24 he Fu	Med		Examiner: On the bas Nurse Practioner:										ise(s) and manner state ated.
To t		29b. Signature and title of certified	0	6/.	A	29c. License	e number	0		29d. Da	ate signed	(Month-E	Day, Year)
		wing	Clas I	11	mos	119	) 8	7		IV	10	0/2	NIU
		30. Name and address of person	who completed caus	e of death (Iter	Page 1	rint) DWSON	/ 10	10	717	201	1		
State	e	31. Date filed (Month, Day, Year)	32. Re	egistra/s Sign	-	00,00	T PO	1	01		(		
Registra		NOV 0 1 2010	anguas	p. A	and								

Registrar X DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Calvin McNair	1- For State	ate of Marylar	nd / Departm <i>Certific</i>			Mental H		20	10 34161
<sup>∌</sup> Physician/	Registrar  1. Decedent's Name (First, Midd	le,Last)					2. Date of Dear	eg. No. th Day Year	3. Time of Death
Medical Examiner	4a. Facility Name (if not institution	Calvi	n		CNair	ocation of Death	October 2	3, 2010 4c. County of	2252 hrs
	Johns Hopkins Hospi		Del)		Baltimore	cation of beaut		40. Godiny of	boaut
Funeral	5. Social Security Numberna	6. Sex 7.	. Age (In yrs. last birt	hday)	If Under 1 Year Months Days	If Under 24Hrs Hours Min.	_	th(MM/DD/YYYY)	Birthplace (State or Foreign Country)
Director		<b>¾</b> ¾ M 2 F	20	Yrs.	Months Days	Hours Min.	6-2	-1990	MD
Aut	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Locatio	n				10d. Inside City Limits
snd show	MD	na	Baltin	nore					1 X Yes 2 No
the Maryland a or 28a-f show any tifted at once. Director	10e. Street and Number	1	•		10f. Zip Code	1.6	11	0g. Citizen of Wha	t Country?
ith the 23a or notific	3333 Winte		lent Ever in U.S.	12 Was	2122 Decedent of Hispa		posific Vos or No	USA	American Indian, Black,
r death with th , or items 23a must be noti	1 X Never Married 2 M				s, specify Cuban, M			White,	
after d		orced If Yes, Give Year or Dates:		_		specify:		Specify:	Black
2 hours "natus Exam	<ol> <li>Decedent's Education (Spe Elementary/Secondary (0-12)</li> </ol>				S Usual Occupation of working life. De			16b. Kind of Busi	ness/Industry
5-0036 ed within 72 hours aft tygiene. other than "natural" the Medical Examing Completed by	12th grade	35,1035 (1.1.	,	St	udent			Trade	School
	17. Father's Name (First, Middle, Stanford Mc					.Mother's Name Mia Mo		Maiden Surname)	
2121, 2121, d Mental be fill a Mental be fill is marked tite event, I To Be	19a. Informant's Name/Relations	hip (Type, Print )	198	o. Mailing /	Address (Street a	nd Number or F	Rural Route Num	nber, City or Town,	State, Zip Code)
MD ad 2 sho alth and m 27 is aumati	Charles Col	eman-Gran			N. Spri			lto, MD	
Baltimore, ME permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum.	20a. Method of Disposition  1 K Burial 2 Cremation	n 3 Removal from	State cremate	ory or othe		- ·	Date 29-10		ity or Town, State
ltime it. Pag rtment ortant: y or ot	4 Donation 5 Other Sp 21. Signature of Funeral Service		ME		el Cem			Balto,	
Ba perm Depa Impo	Somette)	K. In	2)		Ol E. No			East F Balto,	
Physician	23a. Part I. Enfer the disease, or failure. List only one cause	complications that cause on each line.	sed the death. Do no	ot enter the	mode of dying, su	ch as cardiac or	respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
Examiner	Immediate Cause (Final disease or condition resulting in death)		und of Right Bu	ttock					Death
	Sequentially list conditions,	Due to (or as a co	onsequence or):						
iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a co	onsequence of):						
iz iz Kam	(Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence of):						
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.  The law requires that the death certificate be executed the Funeral Director: After this certificate has been signed by the attending physician and appletely filled in by the funeral director, page 2 should be detached for use as the burial - transit directled and the following the properties of the completed by Physician/Medical Examiner	UNPENDED	dAMENDED							
60, ate be ex obysician be burial	IF FEMALE:	23c. If yes, out	tcome of pregnancy					23d. Date of de	elivery
), Box 6876( the death certificate the attending phy ched for use as the b Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live birth		=		Ectopic pregnar	ncy	Month	Day Year
Box e death the atte ed for u	1 Yes 2 No 9 Uni	known 9 Unknowi	3	Otne	r (Specify)				
P.O. s that the greed by e detach.	Part II. Other significant condit	ions contributing to d	eath but not resulting	in the un	derlying cause give	en in Part I.			re to the cause of death?  Probably 4 Unknown
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the real acted.  In Director: After this certificate has been signed by led in by the funeral director, page 2 should be deach ertification: To Be Completed by Pertification: To Be							24a. Was a	an 24b. We	re autopsy findings available
e law r te has b ge 2 sh							autops perfor	med? dea	or to completion of cause of ath?
ital Recitian: The certificate rector, page	25. Was case referred to medica				26.Place of	Death (Check of		2 10 1	Yes 2 No
f Vita Physicia or this ce ral direc	examiner? 1 Yes 2 No	Hospital: 1 🗸 Inp		· .		her 4 Nursing			Other:
n of viding Ph.  : After t shueral	27. Manner of Death  1 Natural 5 Pend	28a. Date of (Month, Date of 23, 20	Injury 28b. 1 ay <sup>Year)</sup> 2117	Time of Inju 7 hrs	1 1	at Work? 2 ✓ No	28d. Describe h Subject shot	now injury occurred t	
Division o spital or Attending nours after death nours after death rilled in by the fune Certification:	2 Accident Inves	stigation	of Injury - At home, fa	rm, street,		ding, etc.			or Rural Route Number, City
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Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	29a. Certifier 1 Certifying Pl	hysician: To the best o miner:On the basis of e	of my knowledge, dea	nth occurre	d at the time, date	and place, and	due to the cause	e(s) and manner as	s stated.
To the Bo within 24 To the Fu complete!	29b. Signature and title of certifie	and manner stat	ed.	2000	29c. License n	-			(Month, Day, Year)
	Als		75	1)	O.C.M.I	E.		October 24,	2010
\	30. Name and address of person				1			1	
	Russell Alexander MD	Assistant Me	dical Examiner	111 F	Penn Street, Ba	altimore, MD	21201		
State Registrar		32. Regis	strar sotgnatur	del.					

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTO be Year 2.56PM Jeffreg 2010 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Glen Burnie Anne Arundel Hospita] If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Age (In vrs. last birthday) **Funeral** 49 Months Days Hours Min. (Month, Day, Year, 3-9-196) Director 216-76-6478 MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menhal Hygiene.
Important: If firem 27 is marked other than "natural" or any injury or other trainment. 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2x XNo MD Pasadena Anne Arunde 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8341 Catherine Avenue 21122 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11. Marital Status 14, Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1X Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 🔽 No Specify: 3 Widowed 4 Divorced Specify: Completed Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) na Elementary/Seconday (0-12) 12th grade NΙΑ College (1-4 or 5+) yrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Horace Martin Mary F. Bowser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa Martin- Sister Pasadena, MD 21122 8341 Catherine Avenue 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Mt Zion Cemetery 10-23-2010 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) Lansdown, MD March East F/H 21. Signature of Fun . Name and Address of Facility 1101 E. North Avenue Balto, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ moxic disease or condition Medical resulting in death) Due to (or as a cons Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 month Day Pregnant at time of death Unknown Month Year ed by the a detached t 9 Unknown ias been signed by 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed' **Director:** After this certificated in by the funeral director, pag 2 No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) 8 examiner? Other: 2 No 잍 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? Natural 5 Pending 2 No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier ζ

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Back River Neck load Balhoure MO)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

palhi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death nt's Name (First, Middle, Last) 2. Date of Death 3. Time of Death
4, 20 A M ) Hopth ben Physician/ 2090 Medical 6. City, Town, or Location of Death Burnie Name (if not institution, give street and number County of Deat Examiner tone t Washington trunde If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Month gay, Country) 213-36-2 1 M 2 □ F MD Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 2/225 3033 Funeral USA Ascension 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 3 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 Mo Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DD NOT use retired) College (1-4 or 5+) Be 18. Mother's Name (First, Midd) State, Zip Code, 19b. Mailing Address (Str trederic 20a. Method of Disposition Place of Disposition (Name of 20c. Location - City or Town, State 20b 1 📈 Burial 2 🗌 Cremation 3 🗌 Removal from State Brooklyn 11-2-10 MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Your Kickes @ Fac Gre 23a. Part 1. Enter he disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Metostatic Immediate Cause (Final Sophager Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, cause. Enter Underlying
Cause (Disease or linjury
that initiated events Due to (or sele done autence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 4 Pregnant 9 Unknown 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 2 🗌 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 1 No 1 🗌 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Division of Vital 26. Place of Death (Check only one) Be Hospital: ပ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Marina of Death 1 Natural 28c. Injury at work? 1 ☐ Yes Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred injury 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 3 30,1 30. Name and address of person who dompleted cause of death (Item 23a) (Type, Print) NOS 18 LIVHLE

State Registrar 31. Date filed (Month, Day,

AcLoven,

Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ Month RERNICE MOANEY 11:30 pM 2010 Medical October 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death NORTHWEST HOSPICE RANDALLSTOWN BALTIMORE CO 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 XX AUG. 12 <sup>Year)</sup> 1931 MARYLAND **Director** 212-30-6138 79 Usual Residence of Decedent 28a-f shov 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director BALTIMORE 1 X Yes 2 No MARYLAND N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1111 WHITELOCK ST. U.S.A. 21217 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes If Yes, Give Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify: 3 Widowed 4 □ Divorced Specify: BLACK Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical! 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) life, DO NOT use retired Elementary/Seconday (0-12) College (1-4 or 5+) TIME KEEPER GOV'T PRINTING OFFICE <u>12th grade</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ RUFUS GARDNER SR. MILDRED E. TUTMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Bogat/Daughter Whitelock St., Baltimore, Maryland 21217 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial XX Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation Other (Specify) METRO CREMATORY 10-29-10 BALTIMORE, MARYLAND 22. Name and Address of Facility
WILLIAM C BROWN COM
1206 W NORTH AVENUE COMM FUNERAL HOME P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final olon Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Irrijury that initiated events Examine Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Month Day Year Pregnant at time of death 1 ☐ Yes ∠ p Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown rage 2 sn 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law autopsy performe Yes 2 W 1 Tes Division of Vital Be ( 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No 4 Nursing Home 5 Residence 6 Other (Specify) Mapre ၉ 1 🗌 Yes Other: 1 Inpatient 2 ER/Outpatient 3 I 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending s after death.

I Director: Aff
d in by the fur 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours Funeral Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 2

To the I

complete only one 29b. Signature and title of certifie 20/0

Registrar

DHMH 17 Rev 7/2009

State

cause of death (Item 23a) (Type, Print)

32. Registrar's Sign

		Please	Type or Print in B State of Maryland					•		
		For State Registrar	State of Maryland		rtificate of I			3. No 2010	34164	
Physici		1. Decedent's Name (First, Middle, La		uh a	mma		2. Date of Death Month	Day 24 Year	10 3. Time of Death 213   M	
/Medic Examin		4a. Facility Name (If not institution, give Mercy Medical				Location of Death		4c. County of Dea	imore	
Funeral		5. Social Security Number 6. 8		last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bi	rthplace (State or Foreign ountry)	
Director		Usual Residence of Decedent  10a. State 10b. County	10c City	y, Town or Lo	ocation	1 9	10 24	10	10d. Inside City Limits	
ith the Marylan or 28a-f show	ctor	040 72 11	Timore Ba		nore				1⊠KYes 2⊡No	
3a or 28	al Director	10e. Street and Number			10f. Zip Code	213	109	g. Citizen of What C	ountry?	
be filed within 72 hours after death with the Maryland tial Hygiene. dother than "natural", or items 23a or 28a-f show event, the Podicel Evarifish must be notified at	/ Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Married	12. Was Decement Ever in U.S Armed Forces? 1 ☐ Yes 2 D No If Yes, Give			lispanic Origin? (Spean, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	te, etc.	
2 hours	ted by	3 Widowed 4 Divorced	Year or Dates:	16a. Dece	edent's Usual Occup	pation	16	6b. Kind of Business	Slack s/Industry	
within 7 iene. than "n	Completed	(Specify only highest gr.	College (1-4or 5+)	life.	DO NOT use retired	during most of workin	9	NIA		
in yearloo 6.16. should be filed within ad Mental Hygiene. marked other than imatic event, Ire Ma	Be	17. Father's Name (First, Middle, Last	)	3		18. Mother's Name		aiden Surname)	1	
3 8 8 8	P_C	Hassan Euwi 19a. Informant's Name/Relationship			ng Address (Street	and Number or Pura		City or Town, State,	TC Zip Code)	
t Health tem 27 other tr		Marquise M. M. 20a. Method & Disposition	20b. P	lace of Dispo	osition (Name of	Di		Oc. Location - City o		
partification of permit. Pages 1 a Department of Hec Important: If item any Injury or othe once.		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci	Removal from State (y)	w Ca	matory or other place. Thedra	1 12/30	10 2	Raltimor	e, mi)	
Departing Department on Ce.		21. Signature of Funeral Service Lice	isee	/-	2. Name and Addre	ss of Facility Bra 9, 2134	Willow	ASKHOR SDVING	FUNERAL Rd. BIBBB	
	7-	23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final			1	ng, such as cardiac o	r respiratory arres	st,	Approximate Interval Between Onset and Death	
/Medical Examiner		disease or condition resulting in death)	a. Due to (or as a consequ		re mat	wity			_	
W. Car	iner	Sequentially list conditions,	b. Due to (or as a consecu	uence ofj:						
e executed sian and urial-transit	Due to (or as a consequence of):  Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):									
icate be	dical		d							
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of d 9 □ Unknown	death 3	☐ Ectopic pregnanc☐ Other (specify)	v N/A		23d. Date of d Month	elivery Day Year	
equires that the signed by the signed by the details and be details.	by	Part II. Other significant conditions	contributing to death but not resu	ulting in the u	underlying cause giv	ren in Part I.			to the cause of death?  Probably 4  Unknown	
: The law recate has be cate has be page 2 sho	Completed						24a. Was an autopsy perform 1 ☐ Yes 2	ed? prior to		
ysician ysician iis certif director	lo Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☑ Inpatient 2 ☐	ER/Outpatie	ent 3 DOA Oth	26. Place of Death er: 4 ☐ Nursing Hor		) nce 6 □Other (Sp	necify) N/A	
ding Pl	tion:	27. Manner of Death 1   ↑ Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	Wor	ryat k? Yes 2.⊠XNo	8d. Describe hov	v injury occurred		
or Atter after dea Director in by th	Certification	3 Suicide 6 Could not be determined	e one Place of Initiative At the	me, farm, st	reet, factory, office	2	8f. Location (Stre	State)	Rural Route Number,	
Hospital 24 hours Funeral etely filled	edical C		hysician: To the best of my kno miner: On the basis of examina and manner stated.	wledge, dea	th occurred at the ti		and due to the ca	use(s) and manner		
To the within To the compl	Me	29b. Signature and title of certifier			29c. Licens			d. Date signed (Moi		
•		30. Name and address of person who			Print)	12915 Mercy 1 + Paul	Medica	10/25/ U Cen	ter	
Sta	te.	Katrina 5 31. Date filed (Month, Day, Year)	Daley, MI 32. Registrar's Signa			+ Paul	Piace	: Kaltiw	iore MD	
Registr		NOV 0 1 2010	32. Registrar's Signa	arked						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #6&19b Per INF G909 11/08/10 JH
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** MILLER SYLVIA 1130 A M 2010 OCTOBER\_ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore City N/A 4824 Wright Avenue If Under 1 Year | If Under 24 Hrs. B. Date of Birth (Month, Day, Year)
June 17,1913 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min. 1 ☐ M 2 🕱 F Yrs. 97 Director Virginia 228-09-6783 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland beathment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" ~ "- any injury or other traumatic event." 10c. City, Town or Location 10a State 10b County 10d Inside City Limits 1☆Yes 2 No Director N/A Baltimore City 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4824 Wright Ave. 21205 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☑ No Specify: White Specify: þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Hammond Maxey Adeline Mahaley Belcher ၉ 19a. Informant's Name/Relationship (Type. Print) 1916 1917 Address Street and Number of Rural Route Number City or Town, State, Zip Code) Mrs. Sharon Sprowls (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Baltimore National Cem. 10/27/2010 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MYOCHEDIAL INFARCTION 5 MIN /Medical Due to (or as a consequence of): Examiner METERY CORONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ADRTIC 2 No 3 Probably 4 Unknown Completed HEART FAILURE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an , page 2 autopsy performed? certificate 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Z No မှ 2 ER/Outpatient 3□ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 1 Natural Injury 5 Pending within 24 hours are: con To the Funeral Director: Aft investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D62032 26 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jennifer Hayashi 5505 Hopkins Bayview Circle Balto., MD 21224 32. Registra State

DHMH 17 Rev 1/2001

Registrar

			1 _ State	e of Maryland		artment o			-	- 21	010	34166
Г	Physici	an	Registrar  1. Decedent's Name (First, Middle, Last)	nutolo		Timoato		2	. Date of Dea Month	Day	Year	3. Time of Death
	/Medic		4a. Facility Name (If not institution, give street an John Hop Kins Bayview	d number)	ter	Bal	vn, or Locatio	n of Death	cholar	4c. Ca Bo	ounty of Death	ore Cita
	Funeral Director		5. Social Security Number 092–12–6069 6. Sex 1 ☑ M 2 □	7. Age (In yrs. la	ast birthday) Yrs.	If Under 1 \ Months D	ear If Und		Date of Birt (Month, Da 1g. 19	h y, <i>Year)</i> •1921	9. Birti Coi New	nplace (State or Foreigi untry) York
	Maryland a-f show	ctor	Usual Residence of Decedent  10a. State 10b. County  MD Baltimore	10c. City	, Town or Lo	ocation		Dundal!	ς.			10d. Inside City Limits 1 □Yes 2 ☒ No
	h with the 23a or 28 Ist be no	al Director	10e. Street and Number 1781 Melbourne Road			10f. Zip Co		21222			ited S	
980	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show disal Evanine rust be notified at	by Funeral	Arme 1 □ Never Married 2½ Married 15€	Decedent Ever in U.S d Forces? fes 2 □ No , Give WWII or Dates:	_	Was Deceden If Yes, specify 1 □ Yes 2½			fy Yes or No- can, etc.)		. Race - Amer Black, White pecify:	
21215-0036	t. Pages 1 and 2 should be filed within frment of Health and Mental Hyglene. rtant: If Item 27 is marked other than 'ajury or other traumatic event, the Ma	Completed	15. Decedent's Education (Specify only highest grade completed in the complete state of	ge (1-4or 5+)	(Give life.	dent's Usual C kind of work of DO NOT use r	lone during m etired)	ost of working			of Business/I	ndustry facturing
Maryland 2		To Be C	17. Father's Name (First, Middle, Last)  Joseph Mutolo				18. Mo	ther's Name (F		Maiden Su		
			19a. Informant's Name/Relationship (Type. Print Mrs. Gertrude Marie Mu		1	ng Address <i>(S</i> Melbo						Zip Code) 21222
Baltimore,			20a. Method of Disposition  11 Burial 2 □ Cremation 3 □ Removal 1 4 □ Donation 5 □ Other (Specity)	rom State Ce	emetery, cre s of I		rplace) emeter	-	0/2010	Ba1		, Maryland
Bal	permii Depar Impor any ir		21. Signature of Juneral Service Licensee			2. Name and A Duda—Ru 1922 Wi	se Ave	. Dunc	dalk,	Maryl		1222
A. A. A. A. A. A. A. A. A. A. A. A. A. A	Physician /Medical Examiner	jr.	r	on each line.  ardiac e to (or as a consequence of the consequence of	ence of):	cart	f dying, such	as cardiac or r	respiratory au	rrest,		Approximate Interval Between Onset and Death
8760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	dical Examiner	COPD									
O. Box 6	at the death certific by the attending p tached for use as i	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 5 □ Other (specify) 9 □ Unknown							23d. Date of delivery Month Day Year		
rds, P.	w requires that s been signed k should be deta	by	Part II. Other significant conditions contributing	to death but not resul	lting in the u	nderlying caus	e given in Par	rt I.	23e. Did to			the cause of death?
of Vital Records,	: The law re icate has be ; page 2 shc	Completed							24a. Was autop perfo 1 ∐Yes		24b. Were au prior to death? 1 □ Yes	topsy findings available completion of cause of 2 □No
of Vita	hysician: The la this certificate had al director, page 2	To Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital:	1 Inpatient 2 I			Other: 4 🗆	nce of Death (			□Other (Spec	cify)
Division (	or Attending after death. Director: After in by the fune	Certification: To	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined 28e. I	Date of Injury Month, Day, Year) Place of Injury - At hor building, etc. (Specify	28b. Time of Injury me, farm, start	М	Injury at Work? 1 □ Yes 2	□No	d. Describe h  f. Location (8  City or Tov	Street and i		ıral Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical C	29a. Certifier Certifying Physician: 7 (Check only one) Medical Examiner: On and	o the best of my know the basis of examinat manner stated.	wledge, deal ion and/or ir	th occurred at nvestigation, in	the time, date my opinion, o	and place, an leath occurred	d due to the l at the time,	cause(s) a date and p	and manner as place, and due	s stated. to the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifier	-NO		29c. L	icense numbe	83			signed (Monti	h, Day, Year) -5, Zoio
_			30. Name and address of person who completed $W_1$ $G$ ree hors	山下 四,		Print)	505 am, n	HOPK				Civele
DH	Sta Registr MH 17 Rev 1/2	ar	31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Offiche VOT 2010 2:45 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Johns Hopkins Bayview Medical If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
June 16,1925 9. Birthplace (State or Foreign Country) Maryland **Funeral** 6. Sex 7. Age (In yrs. last birthday) 212-20-0125 1 M 2 F Days Director 85 Yrs June Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD Baltimore Dunda1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1415 Dundalk Ave. 21222 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes. Give 3♣ Widowed 4 ☐ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 9 Years Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ John M. Lorden Elsie M. Ehmke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9326 Ramblebrook Road Baltimore, Maryland 21236 Mrs. Dorothy A. Glab (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗌 Cremation 3 🗀 Removal from State 10/25/2010 Oak Lawn Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Light <sup>22</sup> Duda-Ruck Funeral Home of Dundalk, Inc. in Dundalk, Maryland 23a. Part 1. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury imprestive the Hospital or Attending Physician: The law requires that the death certificate be executed month that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2.20 1 Tes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: မ Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical LX Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D5629 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue, GLENN A. HIRSCH

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

0 1 2010

4940

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Month Physician/ 8:35 pm ID Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Name (if not institution, give str Hospice Kaltimore If Under 1 Year If Under 24 Hrs Age (In yrs. last birthday 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours Mg 1 □ M 2 🛛 F Months **Director** Usual Residence of Decedent 10a. State City, Town or Location 10d. Inside City Limits with the Maryland injury or other traumatic event, the Medical Examiner must be notified at Director BaltiMore 28a-f 1 X Yes 2 ☐ No 10f. Zip Code 10g. Citizen of What Country? ò 10e Street and Numbe Funeral "natural", or items 23a permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" \_\_\_\_\_ any injury or other transmass. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

FACKET 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First 19a, Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Method of Disposition

1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Place of Disposition Name cemetery, crematory or oth 4 Donation 5 Other (Specify) soad 21. Signature of Funeral Service Lensee arulana 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Pregnant at time of death Other (specify) been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy has within 24 hours after death.

To the Funeral Director: After this certificate Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 25 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of De th 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: injury work? Natural 5 Pending 2 | No Investigation filled in by the Accident Suicide 6 🗌 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier соmpleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatule 29d. Date signed (Month, Day, Year) (Item 23a) (Type

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed

(Month, Day, Year,

NOV 0 1 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Neels 1:45 PM agnes 2010 ctober /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Copper Ridge Sykesville Carroll Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 06/12/1918 Year) 213-18-2097 **XX** M 2□ F 92 Months Davs Hours Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show Item 27 is marked other than "natural", or Items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 □Yes 2 XX Director Maryland Carroll Svkesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21784 7200 Third Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Ares 2 □ NoWNII If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes XX No Specify. Specify: White þ 3XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Advertising Manager Newspaper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roy Cleveland Neely Lillian Wagner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other tra DTR Barbara Neely Sample 41121 Bryn Bach Lane Leesburg, Virginia 20175 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State Union Cemetery 10/28/10 Leesburg, Virginia 4 Donation 5 ☐ Other (Specify) gnature of Funeral 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease or complicat shock, or heart failure. List only one ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Approximate Interval Between Onset and Death Immediate Cause (Final nenia ST Physician a disease or condition resulting in death) /Medical Due to (or a a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) Examiner It am, leading to immedit cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transi Due to (or as a consequence of): nding physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) P.O. P 1 Tyes 2 No. detached 9 D Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page, death? 1 ☐ Yes 2 ☐ No perform ement 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 4 Sursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 10 this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After N Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: the 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled | by determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

645

32. Registrar's Signature

Eldersbury MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#5perFH, G910.12/1/2010, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER NORRIS 2010 PM 00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE JOHNS HOPKINS BAYVIEW MEDICAL CENTER 5. Social Security Number 9825 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Min. 1 🗆 M 2 🛂 Months Hours (Month, Day, Yea MARYLAND Director Usual Residence of Deceder f show 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f shov 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director LTIMORE 1 Yes 2 No INDALK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A PRESSURY APT. 113 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Thomas EICHELBERGER RESSIE ELEANORE M 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co e) EXHELPERGER 3047 LORENA ANE. BATTMORE, MD. 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ott Page 1; 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) RUNDEL CREMEROAY 10-14-10 ODENTON, MD. permit. 21. Sign 22. Name and Address of Facility DAUGHERTY FUNERAL HOME PASADERA MD. 21122 ZGOI MOUNTAWRD. Fart 1. Enter the disease or com-shock, or heart failure. List only on ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onget and Death Immediate Cause (Final RESPIRATURY Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 1 DA VOLUMB OVERLOAD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last the Hospital or Attending Physician. The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter completed filled in by the funeral director, page 2 should be detached for u in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 ☐ No 2 No Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 1 🗌 Yes 2 - No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? ☐ Accident ☐ Suicide Investigation 6 Could not be 2 🗌 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) OCTOBER 12, 2010 M.D RES -000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 EASTERN AVENUE, BALTIMORE, MD, 21224 0 STRUNK BRADLEY M.D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 01 2010 acke Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene dr., 2909,11/01/2010dhb 1 - For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Oliver Curtis Clarence 10-08-2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Center Ft. Washington Medical Washington If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min Months Hours 1⊠M 2□F 33 06-01-1977 Director 216-08-5555 Wash. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits 28a-f show 7 Is marked other than "natural", or items 23a or 28a-f sho traumatic event, it a Medical Examinar must be notified at Director 1XYes 2 No Prince George's MD Ft. Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8374 Indianhead Hwy., Apt.#B1 20744 U.S. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 ∐Yes 2**X** No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. Elementary/Secondary (0-12) 12th Grade College (1-4or 5+) Moving Moving : 1 and 2 should be filed wi Health and Mental Hygier tem 27 Is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Oliver Unknown 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Pages 1 and 2: Department of Health a Important: If Item 27 Is any Injury or other tra Laura E. Hymes / Wife 5407 2nd Street, NW / Washington, DC 20011 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Park Crem. 10-12-10 Riverdale, MD 22. Name and Address of Facility Murkay + Tellington Funeral 21. Signature of Funeral Service Licensee 14804 Georgia Ave, WW. 20011 ines Home 23a. Parrf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis Physician /Medical Due to (or as a consequence of): **Examiner** Kerracido 111 110 Sequentially list conditions, it cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of the death certificate be executed and Due to (or as a consequence of) physician a the burial-Box 68760, Physician/Medical attending p as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.O. I 1 □Yes 2 □No the detached 9 Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ▼No 24a. Was an icate has t page 2 s autopsy performed? Yes 2**X**1No certificate 1 ☐ Yes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA this After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 X Natural 5 Pending No the Funeral Director; Aft

To the Funeral Director; Aft investigation 1 Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0065385 October 8, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alex Rosin 11711 Livingston Rd. / Ft. Washington, MD 20744 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

NOV 0 1 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 0900 ZOIC ar Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death ElderPl Baltimore Hookins Hssister Balti more If Under 24 Hrs. 8, Date of Birth If Under 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** (Month, Day, Year) eb. 2, 1929 1 M 2 F Months Days Hours Min. West Virginia 81 Director 190-22-5628 Yrs Feb. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic and incertain and any injury or other traumatic event, the Medical Examiner must be notified at anotes. 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 Yes 2XXNo Glen Burnie MD <u>Anne Arundel</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 1244 Aster Drive 21061 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. b 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: If Yes, Give Year or Dates Specify 3X Widowed 4 □ Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 9 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Mary Zabik John Powasser 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sandra M. Solano (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 21 Cremation 3 Removal from State Hilltop Service Corp. 10/23/2010 Towson, Maryland 4 Donation 5 Other (Specify) 21. Signature of Fundal Service Licen 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Dundalk. 7922 Wise Ave. 23 Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. It only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ 0 enocarrinom 017 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): physician and s the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death certificate has been signed by the irector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dementia 1 Yes 2 No 3 Probably 4 Mnknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed 2 🗆 No 1 Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) Other: Certificate: To I 1 🗌 Yes 2 No Host Living 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1C

State Registrar

DHMH 17 Rev 7/2009

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Oct. Otto 2010 Marie 10:06A Jean Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 2604 Lynbrook Road Baltimore Co. Dundalk 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min. (Month h 4, 1943 1 M 24X F 67 Director 214-38-4318 Yrs Virginia March Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at. 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Dundalk MD Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21222 2604 Lynbrook Road within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black White etc. 1 Never Married 2 K Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Steel Industry 12 Years Supervisor be filed v Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once. Elizabeth Evelyn Breeden Robert William Colvin Husband 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Frederick Oberlin Otto 2604 Lynbrook Road Baltimore, Maryland 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🖾 Burial 2 🗌 Cremation 3 🔲 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/29/2010 Oak Lawn Cemetery Baltimore, Maryland 21. Signature of Funeral Servi 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, 7922 Wise Dundalk, Maryland Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ worker Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year signed by the at Id be detached fo Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>و</u> 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has funeral director, page 2: autopsy performed 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 5 Pending Natural ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled i by 4 Homicide determined

within 24 hours are deat

State Registrar

Medical

31. Date filed (Month, Day, Year, NOV 0 1 2010

(Check only one

29b. Signature and title of certifier

30. Name and address of person

Yo completed cause of death (Item 23a) (Type, Print)

HULL COL 1124 Mace AVE. Bath, MD. 2122 32. Registrar Signatur

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dead occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

#35593

29d. Date signed (Month, Day, Year) 10/25/2018

29c. License number

State Registrar Patrick M.
31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

McGinley 111. v.

October 27, 2010

Sinai Hospital of Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death Physician/ Month Petry Myrle Carolyn October 2010 7:24 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Westminster Carroll Hospital Center Carroll 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Sept. 19, 1930 Maryland 1 M 2 T **Director** 214-28-1039 80 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at items 23a or 28a-f sho ner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director New Windsor 1 X Yes 2 No Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 1306 Old New Windsor Rd. 21776 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Pump manufacturing Purchaser Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ellen Nusbaum George Bankert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 255 Sunset Dr., Hanover, PA 17331 George F. Petry III - son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🙀 Burial 2 □ Cremation 3 □ Removal from State 10/28/2010 New Windsor, MD 4 ☐ Donation 5 ☐ Other (Specify) Winters Cemetery 21. Sign ur of Funeral Sarvice Licence 22. Name and Address of Facility Hartzler Funeral Home 310 Church St., New Windsor, MD 21776 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. Cause (Disease or linjury that initiated events resulting in death) Last the burial-tran the attending physician and Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death g Unknown 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 XNo 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy ertension After this certificate 1 Yes 2 No Yes To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was cose referred to medical examiner? 26. Place of Death (Check only one) 2 X No 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month. H0061206 10

Registrar

DHMH 17 Rev 7/2009

State

Registrar's Signa

inster

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 21:30 PM October **Physician** epne 2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Days **Funeral** 1 🗙 M 2 🗆 F 68 Yrs 10/25/1942 NY 116-34-1056 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he marked once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1X Yes 2 □ No Director McLean VA 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number U.S.A. 22102 7414 Old Maple Square Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 XMarried 1 ☐ Yes 2√2 No Specify: White If Yes, Give þ 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) 5+ Business <u>Business Owner</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Simon Peskoff Lila Braun 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7414 Old Maple Square, McLean, VA 22102 Karen Peskoff (Wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition ¥ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of F heral Service Licensee 10/31/10 Oregon, OH Beth Shalom Cem. Timothy Harman 22. Name and Address of Facility Robert H. Wick-Wisniewski FH, 2426 N. Reynolds Road, Toledo, OH 23a. Part 1. Enterthe disease, or complications that caused the death. Shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Hear Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last onsequence of Examiner Due to (or said or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 $^{\mathcal{L}}_{\mathcal{A}}$ Medical IF FEMALE 23d. Date of delivery If yes, outcome of pregnancy Physiclan/ 23b. Was decedent pregnant 3 Ectopic pregnancy Live birth 2 Fetal death Month Day Year in the past 12 months? Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 🗌 Yes 1 Tyes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 1 Inpatient 5 🗆 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 🗆 DOA 1 🗌 Yes မှ this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Manner of Death Injury at Work? Certification: Injury 1 Natural 2 Accident 5 Pending investigation 1 🗌 Yes 2 🗌 No filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Director: 3 🗌 Suicide 6 Could not be 4 Homicide hours 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (check only one) o the Ho within 2' 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier October 27, 2010 30. Name and address of person who completed cause of eath (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 IM

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

2010

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ichael Picarello	State of Maryland / 1- For State Registrar	Certificate of	f Health and Mental H f Death	ygiene Reg.	No. 2010	34177
Physician fedical Examine	Decedent's Name (First, Middle,Last)			2. Date of Death Month C October 27,	Day Year 2010	3. Time of Death 1102 hrs
Marie Carlo	4a. Facility Name (if not institution, give street and number)	1	4b. City, Town, or Location of Death		4c. County of Death	
Funeral	8525 Philadelphia Road  5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	Rosedale  If Under 1 Year If Under 24Hrs	8. Date of Birth	Baltimore Cou	nplace (State or
Director		3 Yrs.	Months Days Hours Min.	8-10-	1957 Foreign	n Intry) MD
any		10c. City, Town or Locati				10d. Inside City Limits
Maryland 28a-f show 1 at once.	MD Baltimore	Baltim				1 Yes 2X No
the Maryland a or 28a-f sho tiffed at once.	10e. Street and Number 8525 Philadelphia Road		10f. Zip Code 21237		. Citizen of What Coun USA	try?
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mantal Hygiera in Mantal Hygiera I important: If items 23a or 28a-15th Important: If items 17 is marked other than "natural", or items 23a or 28a-15th injury or other traumatic event, the Medical Examiner must be notified at once To Re Completed by Euroral Director			s Decedent of Hispanic Origin? (Spees, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Americ White, etc.	can Indian, Black,
fter dea	3 Widowed 4 Divorced If Yes Give Year	x № 1	Yes 2 X No specify:		Specify: Whi	ite
hours aft natural" Examine		during me	t's Usual Occupation (Give kind of vost of working life. DO NOT use reti		6b. Kind of Business/Ir	ndustry
21215-0036 Montal Haygene. marked other than "natte event, the Medical Exar	Elementary/Secondary (0-12) College (1-4 or 5-		nager		Maintenar	nce
215-0036 be filed within 7 mtal Hygiene. rked other than ent, the Medica			18.Mother's Name	(First, Middle, Ma	iden Surname)	
LD 21215-005, should be filed with and Mental Hygiene 7 is marked other that event, the Med To Be Com		19b. Mailing	Patric Address (Street and Number or F		se <u>Malin</u> c er, City or Town, State,	
re, MD s: 1 and 2 sho of Health and If item 27 is ner traumati	Charles Malinoski- Uncl		Rockburne Ro		dalk, MD	
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and In Important: If item 27 is in injury or other traumatic	20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State	crematory or oth			•	, .
Baltim permit. Pa Departmer Important injury or or	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee		- 1			neral Home
	23a. Part I. Enter the disease, or complications that caused the	PA	. 2134 Willow	Spring	Road. 21	
Physician	failure. List only one cause on each line.  Immediate Cause (Final disease a. Hypertensive Ath			respirately arrest	, arroad, or mount	Between Onset and Death
xaminer	or condition resulting in death)  Due to (or as a consection)					
2	Sequentially list conditions, if any, leading to immediate Due to (or as a consect cause. Enter Underlying Cause	juence of):				
led nsit Examiner	(Disease or injury that initiated events resulting in death) Last    C.  Due to (or as a consection)	quence of):				
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ficate be exg physician the burial	IF FEMALE: 23c. If yes, outcome 23b. Was decedent pregnant in the 1 Live birth		tal death 3 Ectopic pregna	nou	23d. Date of delivery  Month Da	ay Year
box 68760, the death certificate be the attending physic ched for use as the burned Physician/Mod	past 12 months?  4 Pregnant at ti		al death 3Ectopic pregna ner (Specify)	icy .	World Da	ay rear
D. Bc		but not resulting in the u	nderlying cause given in Part I.	23e. Did toba	cco use contribute to the	ne cause of death?
S, P.O iires that to a signed b	chronic alcoholism		······	1 Yes	2 No 3 Proba	
of Vital Records, is Physician: The law requires the this certificate has been signeral director, page 2 should be an To Re Commission.				24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of
tal Rection: The certificate ector, page			26.Place of Death (Check of		No 1 ✓ Yes	2 No
f Vital Physician or this certi ral director	1 ✓ Yes 2 No Inpatient		3 DOA Other Nursing	Home 5 Re	esidence 6 🗸 Other:	Scene
_ ≗ . ₹ द । ह	27. Manner of Death 28a. Date of Injury (Month, Day,Yea	y 28b. Time of Ir ar)	njury 28c. Injury at Work?	28d. Describe how	v injury occurred	
Division o To the Hospital or Attending within 24 hours after death To the Funeral Director: After completely filled in by the funeral political Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Inju	ıry - At home, farm, stree	t, factory, office building, etc.	28f. Location (Stre or Town, Stat	eet and Number or Rura	al Route Number, City
Hospital Hoburs Tuneral	Z9a Certiler	knowledge death occur	red at the time, date and place, and	due to the cause(s	s) and manner as state	d.
To the Hospital within 24 hours To the Funeral completely filled	(Check only one) 2 Medical Examiner: On the basis of examinand manner stated.					
2	29b. Signature and title of certifier		29c. License number O.C.M.E.	18.05	9d. Date signed (Moni	th, Day, Year)
		ah (Item 23a)				
			111 Penn Street, Baltimore	, MD 21201		
Stat Registra	NOV 01 2010 Conserved	s Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month <u>October</u> 2010 5:45 A Medical Name (if not institution, give street and num 4b. City, Town, or Location of Death Examiner 4c. County of Death **Baltimore** MONIUW) Age (In yrs. last birthday) Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 215-07-7425 1 🗆 M 2 🔀 F Months Days Hours Min. 12/21/1917 **Director** MaryTand Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic area. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Timonium 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 U.S.A. 20 Bussing Court 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify. 3 🕅 Widowed 4 🗆 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Retail Merchandiser Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Frances I. Eccles Julian C. Finnegan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 Bussing Court Timonium, Maryland 21093 <u> Clare A. Finnegan/Sister-in-law</u> 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 10/29/2010 4 Donation 5 Other (Specify) Towson, Maryland Hilltop Serv. Corp. 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Lice 0 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Dementie Physician Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 Phalen IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths?
1 Yes 2 No 5 Other (specify) Month Day Year 1 Yes 2 9 Unknown 9 🗌 Unknown signed by the P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death. Funeral Director: After this certificate has autopsy 2 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Other: Certificate: To 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 5  $\square$  Pending Natural 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Framiner On the basis of exemination and/or investigation in more investigation. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 578 31. Date filed (Month, Day, Year) 32. Registra is Signat State Registrar

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DHMH 17 Rev 7/2009

Registrar DHMH 17 Rev 1/2001

P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 Frederick Charles Raab III October 7:00 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 715 Maiden Choice Lane Apt. PV 301 Baltimore Catonsville 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 6. Sex 1 X M 2 ☐ F Country)
Mary Land Months Hours Min Month, Day, Feb 28 Director 86 <u>215-14-5594</u> Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hyglene. is marked other than "natural", or items 29a مه 200 م 28a-f shov 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits notified a 1 🗆 Yes 2 XNo Baltimore Catonsville Maryland 10e. Street and Number 10g. Citizen of What Country? ems 23a or Funeral 715 <u>Maiden Choice Lane Apt. PV 301</u> 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No 1942
If Yes, Give
Year or Dates. 1945 Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Purchasing BGE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Page 1 and 2 should be f tment of Health and Menta tant: If item 27 is marked jury or other traumatic en Frederick Charles Raab Jr. Alverta Gilespi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth B. Raab, Wife 715 Maiden Choice Lane Apt. PV 301 Catonsville, Maryland 21228 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If its
any injury or of 1 D Burial 2 X Cremation 3 Removal from State Metro Crematory Inc. 4 ☐ Donation 5 ☐ Other (Specify) 11/01/10 Baltimore, Maryland Name and Address of Facility Cemation Society Of Maryland, Inc. 39 Frederick Road Baltimore, Maryland 21228 21. Signature of Funeral Service Licensee Thomas Gregor 23a. Part 1. Enter the dise file, or contributions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ 78970MG Metatatic Jerr disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): **Hospital or Attending Physician:** The law requires that the death certificate be executed 24 hours after death. that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year Pregnant at time of death 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital 2 No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural Natural 5 Pending injury s after death. Accident nvestigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined Medical 29a. Certifier 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 033409 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

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32. Registrar's Signature

Rd H415, Limer. 11e

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filed (Month, Day, Year)

10-08183 William Spears Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Villiam Spears		State of Maryland / Department Certificate  Certificate			, No. 2010 34181
Physicia Medical Exami	an/	1. Decedent's Name (First, Middle,Last)		2. Date of Death Month	Day Year 3. Time of Death
yiegicai ⊑xami	ner	William Spears  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	October 26	, 2010 0014 Hrs 4c. County of Peath
		University Hospital	Baltimore		NA
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Months Days Hours Min		(MM/DD/YYYY) 9. Birthplace (State or Foreign
Birector		218-48-1695  1 M 2 F   63 Y	rs.	Dec 2	4, 1946 Country) ML)
v any		10a. State 10b. County 10c. City, Town or Loc	ation		10d. Inside City Limits
vfaryland 28a-f show 1 at once.	tor		Himore	1.0	1 Ves 2 No
5-0036 led within 72 hours after death with the Maryland dygiene. other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once.	Director	1709 MCKan Ave	10f. Zip Code 21217	100	g. Citizen of What Country?
h with 1 ms 23s	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. V	Was Decedent of Hispanic Origin? ( Sper f Yes, specify Cuban, Mexican, Puerto R		14. Race - American Indian, Black, White, etc.
ter deat ", or ite		1   Never Married   2   Married   Armed Forces?   1   Yes   2   No   3   Widowed   4   Divorced   If Yes, Give Year   1	Yes 2 No specify:	aroun, etc.)	specify: Black
ours afi atural' kamine	d by	lor Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent 16a. Decede	lent's Usual Occupation (Give kind of wo		16b. Kind of Business/Industry
36 in 72 h han "n tical E	plete	Elementary/Secondary (0-12) College (1-4 or 5+)	most of working life. DO NOT use retired	(10)	Transportation
5-0036 led within 72 tygiene. other than '	Completed	17. Father's Name (First, Middle, Last)	18.Mother's Name (I	First, Middle, M	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Elmer R. Spears, Si.  19a. Informant's Name/Relationship (Type, Print)  19b. Mail	Verti	ereditt,	
MD 2 d 2 shoul Ith and M n 27 is m numatic	ပ	Haula Horshaw - Sister 1207	ling Address (Street and Number or Ru Suter Kd., Ca-	HONS VI	
그 뒤 양 등 끝내			osition (Name of cemetery,	Date	20c. Location - City or Town, State
Baltimore, permit. Pages 1 a Department of He Important: If ite		4 Donation 5 Other Specify: Wood (		2010	Baltimore, MD
Baltimo permit. Page Department Important: injury or otd		21 Chature of Funeral Service Licensee	Name and Address of Facility	well i	Ave, Baito MD31307
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not ente failure. List only one cause on each line.			
/Medical xaminer		Immediate Cause (Final disease or condition resulting in death)  a. Gunshot Wounds (2) of Torso  Due to (or as a consequence of):			Death
		Sequentially list conditions,  b			
	Examine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause [Disease or injury that initiated			
D. at List		events resulting in death) Last  Due to (or as a consequence of):  d.			
68760, certificate be executed ading physician and see as the burial - transit	Physician/Medical	UNPENDED X AMENDED #28b, perME, G91	1 1/29/2011 170		
Box 68760, e death certificate be ex the attending physician cd for use as the burial	/Me	23b. Was decedent pregnant in the			23d. Date of delivery
	iciar	past 12 months?  past 12 months?  4 Pregnant at time of death 5	Fetal death 3 Ectopic pregnand Other (Specify)	су	Month Day Year
J. Bo	Phys	1 Yes 2 No 9 Unknown 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I	23e Did tob	pacco use contribute to the cause of death?
P.C sthat igned	اھ	The state of the s	s and drying couse given in Fair i.		2 ✓ No 3 Probably 4 Unknown
ords, I	Completed			24a. Was ar autops	
Reco	E			perform 1 ✓ Yes 2	
Vital   Vital   ysician: his certif	å	25. Was case referred to medical examiner?  1. ✓ Vos. 2. No. Hospital: 1 Inpatient 2. ✓ ER/Outpatie	26.Place of Death (Check on other 3 DOA Other 4 Nursing		Residence 6 Other:
of Vital Records, ling Physician: The law requir After this certificate has been s functed director, page 2 should	2	27. Manner of Death 28a. Date of Injury 28b. Time of	of Injury 28c. Injury at Work? 2	28d. Describe ho	ow injury occurred
~ = : ` ∈	ation	1 Natural 5 Pending Oct 26, 2010 Pnd: 5:2	22 AM 1 Yes 2 No	Subject shot	
Division pital or Attendi ours after death. eral Director: #	ertification:	3 Suicide 6 Could not be determined (Specify) Local Street in a car			reet and Number or Rural Route Number, City ate) Avenue, Baltimore, Md.
	O	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occ	curred at the time, date and place, and d	ue to the cause	(s) and manner as stated.
To the Hos within 24 h To the Fun completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigand manner stated.			
	Σ	29b. Signature and title of certifier	29c. License number O.C.M.E.	Ì	29d. Date signed (Month, Day, Year)  October 26, 2010
4	ŀ	30. Name and address of person who completed cause of death (Item 23a)			
\			eet, Baltimore, MD 21201		
St Regist	ate	1963 1 2 1 1 1 6 6 1 1 1 1 1 1 1 1 1 1 1 1 1	Ker		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 1 0

		•	For State Registrar	State of M	aryıan -		tificate of		d Mental Hy	giene Reg. No.	010	34182		
	Physicia Medic		1. Decedent's Name (First, Middle,	Agnes		Str	awberr	У	2. Date of De Month	eath Day 2 6	NO 1	3. Time of Death		
	Examin		4a. Facility Name (if not institution,	give street and number)			4b. City, Town,	or Location of De			4c. County of Death			
-	A		Union Memori	al Hospita	al		Balt	imore		n				
	Funeral Director		220-14-0829	5. Sex 7. Ag 1 □ M 2 <b>X</b> □XF	e (In yrs. I 96	ast birthday) Yrs.	If Under 1 Year Months Days		1 8. Date of Bir 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		9. Bir Co	thplace (State or Foreign untry) MD		
	how at	٦	Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Loc	cation					10d. Inside City Limits		
	arylar la-f s ified	Director	MD	na		ltimo						1 ¥ Yes 2 □ No		
	or 28 e not	ة	10e. Street and Number		DGI CIMOLO					10a. Citiz	en of What Co	21		
	with s 23a ust b	Funeral	5240 Darien	Road			21:	206			SA			
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mertal Hygiene. If health and Mertal Hygiene, and Try is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed by Fun	11. Marital Status  1 ☐ Never Married 2 ☐ Marrie 3 ☑ Wildowed 4 ☐ Divorced	If Yes, Give Year or Dates.	Ever in U.S	I	Was Decedent of f Yes, specify Cul		(Specify Yes or No- erto Rican, etc.)	S <sub>i</sub>	4. Race - Ame Black, White Decify Bla	e. etc.		
5-	"nat	ple	15. Decedent (Specify only highes	s Education grade completed)		(Give I	lent's Usual Occu kind of work done	during most of v	working	16b. Kin	d of Business	Industry		
12	ithin 7 ene, than he M	5	Elementary/Seconday (0-12) 8th grade	College (1-4 or 5	ō+)	1	O NOT use retired	•	_	_				
	filed willed will will will will will will will wil	Be (	17. Father's Name (First, Middle, La	st)			mestic		Name (First, Middle			Homes		
'lan	should be filed wit and Mental Hygie is marked other aumatic event, th	욘	James W. Bak	er					B. Bail		,,,,,,,,			
Maryland	2 should be file Ith and Mental I 27 is marked o traumatic eve		19a. Informant's Name/Relationshi Theresa D. Be		ter			t and Number or	Rural Route Number	er, City or To		o Code)		
ē,	permit. Page 1 and Department of Heal Important: If item 2 any injury or other once.		20a. Method of Disposition  1XXBurial 2   Cremation		20b. F	Place of Dispo	sition (Name of natory or other pla		Date		ation - City or	Town, State		
Ë	permit. Page Department or Important: If any injury or once.		4 Donation 5 Other (Sp	ecify)			ore Nat		1-2010		to, M	D		
Ball	permit Depar Impor any in		21. Signature of Funeral Service Lice	110	1		. Name and Addr		March					
_	402 % 6	-	23a. Part 1. Enter the disease, or o	K Jmes	<u>ر</u>				Avenue		lto,M	D 21202		
	nysician/ Medical		shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	ly one cause on each line  a.  Due to (or as	s. SvS		er the mode of dy	ing, such as card	liac or respiratory ai	rest,		Approximate Interval Between Onset and Death		
	Examiner					10:90s	Sis					one week		
	p ti	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequ	uence of):								
9.	cate be executed physician and the burlal-transit	Exar	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as	Due to (or as a consequence of):									
0	be ey sician burla					·								
1260	icate g phy: is the	Medical		d										
. Box 68	or Attending Physician: The law requires that the death certificate be executed are death. After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burlal-transit	< ∣	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼ No 9 ☐ Unknown	1 Live Birth	ic. If yes, outcome of pregnancy  1					23	3d. Date of de Month	livery Day Year		
P.O.	that the deaned by the a detached to		Part II. Other significant condition	s contributing to death b						obacco use	e contribute to	the cause of death?		
S,	ulres ti n signi uld be	Completed by							_ 1 🗆	Yes 2	No 3 💢 P	robably 4 🗌 Unknown		
Ö	iw require is been si 2 should b	plet							24a. Was		24b. Were au	topsy findings available completion of cause of		
Rec	sician: The law certificate has irector, page 2	팃								ormed?	death?	s 2 No		
<u></u>	ysician: is certifica director, I	Be	25. Was case referred to medical examiner?				26. 1	Place of Death (C		2/22/110]				
Ξ	hysic his ce	၉	1 Yes 2 XNo			ER/Outpatien	nt 3 🗆 DOA Ot	her: 4 🗌 Nursin	g Home 5 🗆 Resi	dence 6	Other (Spec	eify)		
Division of Vital Records,	Attending Physi r death. ector: After this o by the funeral dire	Certificate:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investige			28b. Time of injury	28c. Inju wo M 1		28d. Describe	how injury o	occurred			
ivisi	or Atte a er de Directo In by th	Certif	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin				eet, factory, office	,	28f. Location ( City or Tox		Number or Ru	ral Route Number,		
	To the Hospital or Attend within 24 hours are death To the Funeral Director A completed filled in by the f	Medical	(Check 2 \(\sumeq\) Medical Ex	Physician: To the best of aminer: On the basis of e Jurse Practioner: To the	xaminatio	n and/or invest	igation, in my opir	nion, death occurr	ed at the time, date	and place, a	nd due to the	cause(s) and manner stated.		
	To the comp		29b. Signature and title of certifier	w.				se number	,, 340 10 11		signed (Monti			
	3		Mus He	hui - Ir	rter	^	AT2	13894	6	10/2	6110			
	le		30. Name and address of person w				Print)		2 MD			100 Cross ( Dr.		
	Ctot		31. Date filed (Colth, Pay, Vel)											
	Stat	څ	793 TW [ [ 1"   "2]   ]	1 Annual Control										

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death <sup>D</sup>28 2010 **Physician** Theodore W. Schlottenmeier October 4:10 am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Health Care—The Pines. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Talbot Bithplace (State or Foreign If Under 24 Hrs. **Funeral** Months Days Hours Min. 1071071922 New Jersey 88 Director 216-12-7428 Usual Residence of Decedent 10h County 10c. City. Town or Location 10d. Inside City Limits 10a State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatith and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Medical Examinat must be notified at Director 1 ☐ Yes 2 No Talbott Easton Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 30 Park Lane 21601 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 11. Marital Status Race - American Indian. Black, White, etc 1 Yes 2 No If Yes, Give Navy Year or Dates: Navy 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify White ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Government Printing College (1-4or 5+) Factory Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dora Ward Theodore Schlottenmeier 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30 Park Lane, Easton, Maryland, 21601 Ruth Schlottenmeier/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Crematory 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 75 ☐ Other (Specify) 10/29/2010 |Glen Burnie,Marvland 21. Signature of Funeral Service Licenses 22. Name and Address of FacilityGary L. Kaufman Funeral Home Inc 7250 Washington Blvd., Elkridge, Maryland, 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** END STAGE RENAL DISEASE MONTHS /Medical Due to (or as a consequence of): Examiner YEARS CONGESTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine CORONARY and burial-trar Due to (or as a consequence of) attending physician for use as the burtal Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown 9 Unknown signed by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 icate has been si , page 2 should t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No 2 **□**Klo 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2√2No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident

The law requires that the death certificate be executed Box 68760, P.0.

Schlottenmeier

Baltimore, Maryland 21215-0036

Theodore

Hospital or Attending Physician: n 24 hours after death.

Pe Funeral Director: A pletely filled in by the fu death.

Records,

Division of Vital

the

3 Suicide 4 Homicide

29a. Certifier

(Check only one)

Medical within 2

State Registrar

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29d. Date signed (Month, Day, Year) 28 2010

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

610 DUTCHMANS CANE FASTON

1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

RNP REESTOE 32. Registrar's Signature 31. Date filed (Month, Day, Year) MOV 0 1 2010

6 Could not be determined

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 28,2010 2:00A Dorothy M. Stadler Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Balto. Towson Gilchrist 5. Social Security Number 8. Date of Birth (Month, Day, Year) December 2-2 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 M 2X F Days Hours Maryland Director Yrs. 85 1924 218-14-9218 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Md. Balto. Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 9104 Bowline Road 21236 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
White Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give X Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 🗌 Widowed 4 🗌 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 6th Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Margaret William Szymanski Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 804 Elderbank Towson, Md. 21286 Joseph Stadler Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2  $\square$  Cremation 3  $\square$  Removal from State 4  $\square$  Donation 5  $\square$  Other (Specify) Gardens of Faith 11-2-2010 Balto. Md. 21. Signature of Fuperal Service Licen Schimunek Funeral Home 22. Name and Address of Facility 21236 9705 Belair Road Nottingham, Md., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition **Medical** resulting in death) ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Month Day Pregnant at time of death Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ♣ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform After this certificate 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ပ 1 🗌 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending injury work' М 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined thin 24 hours a the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature of certific

HMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

of person who completed cause of death (Item 23a) (Type, Print)

10-08210	
Jason Stigler	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ason Stigler	1	State of Maryland / Department of Health and Mental For State  Certificate of Death		2010 Reg. No.	34185							
Physician		Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of De	ath	3. Time of Death							
ledical Examine		Jason S. Stigler	Month October	Day Year 27, <b>201</b> 0	1341 hrs							
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Dea	ath	4c. County of Deat	n e							
		Johns Hopkins Hospital Baltimore										
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24H	Irs. 8. Date of E	Birth(MM/DD/YYYY) 9. Bi Forei	thplace (State or							
Director	١	212-92-6458   1X M 2 F   32   Yrs.   Months   Days   Hours   M	1in. 04/0		ountry) MD							
	ŀ	Usual Residence of Decedent	01/0	74715701								
any .	L-	10a, State 10b, County 10c, City, Town or Location			10d. Inside City Limits							
p de le	_	PA York Glen Rock			1 Yes 2 XNo							
daryland 28a-f show any 1 at once.	읽	10e. Street and Number 10f, Zip Code		10g. Citizen of What Cou	ntry?							
th the Maryland 23a or 28a-f she notified at once	Director	6184 Steltz Road 17327		U.S.A.								
s 23a s 23a		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (	Specify Yes or N		ican Indian, Black,							
eath v	Funeral	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No	rto Rican, etc.)	White, etc.								
fler d		3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:		Specify: Wh	ite							
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036 ithin in the ne.	립	12 Dependent			Supporting							
5-0 led wi	3	17. Faulei s Name (First, Middle, East)		, Maiden Surname)								
21215-0036  Juld be filed within 7  Mental Hygiene.  marked other than c event, the Medica			/ A. Hi	psley	7.01.							
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other trannatic event, the Medical Examiner must be notified at once	٩	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number of			1							
MD nd 2 sho ulth and m 27 is aumati	1	Cindy A. Kato (Mother) 6184 Steltz Rd., C	Glen Ro	OCK , PA 1 / 3	Z / r Town, State							
Fite fite		4 12 Rusing 2 Compation 3 Removal from State crematory or other place)										
Page Page Tent C		4 Donation 5 Other Specify: St. John Cem. 1	<u>1/1/10</u>	New Fre								
Baltimore, permit. Pages I an Department of Hea Important: If ite	1	21. Signatur, of Funeral Service Licensee T. Harman 22. Name and Address of Facility			ain St.							
<b>M</b> 80 4.1	1	Geiple Funeral	Home,	Inc. Glen	ROCK, PA							
Physician	1	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardial failure. List only one cause on each line.		irrest, shock, or heart	Between Onset and							
ivacical. Examiner	1	Immediate Cause (Final disease a Pulmonary Thromboembolism complicating Arnold Chiari m	alformation		Death							
	-	or condition resulting in death)  Due to (or as a consequence of):										
	اچ	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):										
	Examiner	cause, Enter Underlying Cause (Disease or injury that initiated										
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be ex be ex sician	edical	UNPENDED		Lood Date of delive								
OX 6876C eath certificate attending phys	Š	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic preg	onancv	Month	Day Year							
certif	Sia.	past 12 months?  1 Live birth 2 Fetal death 3 Ecropic pres 4 Pregnant at time of death 5 Other (Specify)	J									
Box 6876( e death certificate the attending phy ed for use as the b	Physician/M	1 Yes 2 No 9 Unknown 9 Unknown										
that the denoted by the detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		tobacco use contribute to								
rds, P.O	<u>۾</u>		_   1Y	res 2 No 3 Pro	bably 4 V Unknown							
cords, aw requir has been s 2 should	e		24a. Wa		utopsy findings available completion of cause of							
COI	Completed			formed? death?	es 2 No							
tal Rec		25. Was case referred to medical 26.Place of Death (Che										
of Vital Records, P.O. ng Physician: The law requires that the structure or signed by the rhis certificate has been signed by the rhis certificate by the structure of the struc	å	examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other Nur	rsing Home 5	Residence 6 Oth	er:							
of Viving Physic	의	27 Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describ	e how injury occurred								
on on on on the fun of	틼	1 V Natural 5 Pending (Month, Day, Year) 1 Yes 2 No										
ivisior or Attenc after death Director:	<u>[</u>	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.		(Street and Number or F	ural Route Number, City							
Division tal or Attending after death.	Certification:	3 Suicide 6 Could not be determined (Specify)	or Town	, State)								
		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a	and due to the ca	ause(s) and manner as sta	ited.							
the ]	edical	one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.	ed at the time, da	te and place, and due to	he cause(s)							
To wit	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month											
		O.C.M.E.		October 28, 20	10							
10	- 1	30. Name and address of person who completed cause of death (Item 23a)										
10		Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 212	201									
Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature										
Registr	rar	NOV 0 1 2010 And I have										

				land / Depa	artment of Healt tificate of Deat	th and M	lental Hyg	_	34186				
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)				2. Date of Dear	th	3. Time of Death				
ā	Medic Examin	al	Charles Pasfield Sammis  4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Locati Sykesvi		October	28 2010 2:15p  4c. County of Death Carroll					
44	Funeral			rs. last birthday)	If Under 1 Year If Un	nder 24 Hrs.	8. Date of Birth		irthplace (State or Foreign				
	Director		084-12-2988	Yrs.	Months Days Hou	urs Min.	Year) 1917	Year) 1917 Country) NY					
	Maryland 28a-f show otified at	Director		Sykesvi					10d. Inside City Limits 1 ☐ Yes 2 ☐No				
	with the s 23a or a	Funeral D	10e. Street and Number 7200 Third Avenue G4		10g. Citizen of What C USA	Country?							
9036	flied within 72 hours after death with the Maryland tal Hygiene. et other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced  12. Was Decedent Ever in Armed Forces?  1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.		Vas Decedent of Hispanic Yes, specify Cuban, Mex ☐ Yes 2 XNo Spec		cify Yes or No- Rican, etc.)	14. Race - Arr Black, Wh Specify: Wh	ite, etc.				
1215-0	within 72 hou giene. <b>ner than "natu</b> <b>it, the Medica</b>	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12)  College (1-4 or 5+) 4	(Give k	ent's Usual Occupation ind of work done during r DNOT use retired) urgist	most of worki	·	16b. Kind of Busines Northrop (	_				
Baltimore, Maryland 21215-0036	ould be filed wind Mental Hygie marked other matic event, til	To Be (	17. Father's Name (First, Middle, Last) William Edmund Sammis		Maiden Surname)								
, Man	2 sh thar thar 27 is trau		19a. Informant's Name/Relationship (Type, Print) Tina Hall (executor)	umber or Rura	Route Number,	City or Town, State, 2 MD 21201	Zip Code)						
more	Page 1 and ment of Heal ant: If item 3 ury or other		1 Burial 2 Commation 3 Removal from State		sition (Name of latory or other place) y Cremation			20c. Location - City of Sykesville					
Balti	permit. Page 1 a Department of H Important: If ite any injury or ot		21. Signature of Funeral Service Licensee	22.	Name and Address of Fa	acility Haig	ght Fune	ral Home					
	Pnysician/		23a. Part 1. Enter the disease, or complications that caused the canon shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	death. Do not enter		n as cardiac o			Approximate Interval Between Onset and Death				
	Medical Examiner		resulting in death)  Due to (or as a con-	sequence of):									
	cuted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events c.										
09	ite be executed hysician and the burial-transit	ical	resulting in death) Last  Due to (or as a consequence of):  d.										
. Box 6876	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE:  23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pre 1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year				
ls, P.O.	uires that the signed by all he detact	þ	Part If. Other significant conditions contributing to death but not	resulting in the ur	nderlying cause given in P	Part I.	23e. Did tob	~/	to the cause of death?				
Division of Vital Records,	The law ate has page 2	Completed					24a. Was ar autops perform 1 \( \sum \text{Yes} \)	y prior to ned? death?	utopsy findings available completion of cause of				
ital	sician: certific rector,	Be	25. Was case referred to medical examiner?  1  Yes 21 No Hospital:		_ Other: >	Death (Check		<i></i>					
n of V	iding Physth. th. After this funeral d	cate: To	27. Manner of De h Natural 5 Pending (Month, Day, Year Accident Investigation	2 ER/Outpatient 28b. Time of injury	28c. Injury at work?  M 1  Yes 2	2		ence 6 Other (Spe w injury occurred	icify)				
Divisio	al or Atter s after dea l Director d in by the	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - A building, etc. (Spe				28f. Location (Sti City or Town	reet and Number or R , State)	ural Route Number,				
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completed filled in by the funeral director.	Medical	29a. Certifier (Check (Check only one) 3 Certifying Physician: To the best of my kr	ation and/or investi	gation, in my opinion, deat	th occurred at	the time, date an	d place, and due to the	cause(s) and manner stated.				
	To the To the Complex	-	29b. Signature and fille of certifier		00059	- 1	2	9d. Date signed (Mon	th, Day, Year)				
D			30. Name and address of person who completed cause of death (I	Thind	Aue Sy	Kesv	1/le /	no 21	784				
	Stat Registra		31. Date filed WOLV DO Ta 2010 22. Registrar's Si	graffyre far	Ked -		7						

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	Otate of Wi	-	Certificate of L			eg. No.				
	Physicia	ın/	Decedent's Name (First, Middle, Las     CHARLES	st)	CIICO	'M A N		Date of Deat     Month	Day Ye	3. Time of Death			
	Medic Examin		CHARLES  4a. Facility Name (if not institution, give		SUSS	4b. City, Town, o	r Location of Death	October	27 2c 4c. County of E				
			Sinai Hospit 5. Social Security Number 6. S		(In yrs. last birth			8. Date of Birth	N/A	Birthplace (State or Foreign			
в	Funeral Director		212-28-1925	M 2 □ F		rs. Months Days	Hours Min.	06971 <sup>h</sup> 271		Country) MD			
	and show	ior	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits			
	Maryl 28a-f	Jirec	MD BALTI	MORE	BAI	TIMORE				1 ☐ Yes 2 🌠 No			
	with the 23a or 1st be r	Funeral Director	10e. Street and Number 3311 MARNAT ROA	D		10f. Zip Code 2120	8	1	I0g. Citizen of What USA	t Country?			
920	1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed by Fun	11. Marital Status 1 ☐ Never Married 2 【※ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Yes, 2   If Yes, Give Year or Dates.		13. Was Decedent of H If Yes, specify Cuba 1 Yes 2 XNo	an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, Vhite, etc. WHITE			
15-0	72 hour	nplet	15. Decedent's E (Specify only highest gr		1 (	Decedent's Usual Occup Give kind of work done	during most of won		16b. Kind of Busin	ess Industry			
21215-0036	within giene. er thar the M		Elementary/Seconday (0-12)	College (1-4 or 5	+)	life. DO NOT use retired; GUIDANCE &	DOLDKAI	SOR NG E	BALTIMORE	CO. SCHOOLS			
pue	should be filed within and Mental Hygiene. is marked other tha aumatic event, the N	To Be	17. Father's Name (First, Middle, Last)		SUSSI		18. Mother's Nan	ne (First, Middle, N	faiden Surname)	TENTENDIAL			
Maryland	should b and Mer is mark aumatic		JACOB H  19a. Informant's Name/Relationship (7)	LEVENTHAL  e, Zip Code)									
	1 and 2 short Health a item 27 is other train		FREDA SUSSMAN/W	IFE	33	311 MARNAT			=				
Baltimore,	0		20a. Method of Disposition 1   Burial 2  Cremation 3  4  Denation 5  Other (Speci		OHEB SHALOM MEM. PK. 10/29/2010   REISTE								
Ball	permit. Page Department. Important: I any injury or once.		21. Signature of Funeral Service Hoog	lem		22. Name and Address 8900 REI			NSON & BROKESVILL	OS., INC. E, MD 21208			
	Physician/ Medical		23a. Parf 1. Enter the diseas., or com shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a Aort	ie St	ehosi s	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death			
	Examiner	J.	Sequentially list conditions,	b. —	a consequence of	,				·			
	ted d insit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury										
_	icate be executed physician and s the burial-transit	al Ex	that initiated events C. Due to (or as a consequence of):										
8760	ificate big physical as the b	Medical		d		* 10 · 10 · 10							
Box 6	The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live Birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 ☐ Ectopic pregnan 5 ☐ Other (specify) _	су		23d. Date o Month	f delivery Day Year			
ds, P.O.	requires that to been signed by should be deta		Part II. Other significant conditions of	ontributing to death b	ut not resulting in	the underlying cause g	iven in Part I.			te to the cause of death?  Probably 4 Unknown			
Records,	The law re cate has be page 2 sho	Completed by						24a. Was a autops perfort	sy prior med?_ deat	e autopsy findings available r to completion of cause of th? I Yes 2 No			
of Vital	ysician: The is certificate director, pag	To Be	25. Was case referred to medical examiner?  1  Yes 2  No	Hospital:	ent 2 T FR/Out	26. F	Place of Death (Che		ence 6 Other (S	Propify			
on of	nding Phy ath. ; After thi e funeral d		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigatio	28a. Date of injui (Month, Day	ry 28b. Ti	me of 28c. Injury wor	ry at		ow injury occurred	респу)			
Division	Hospital or Attending Physiciam: 24 hours after death. Funeral Director, After this certificated filled in by the funeral director,	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	ne l		m, street, factory, office		28f. Location (St City or Town		r Rural Route Number,			
_	To the Hospital or vithin 24 hours after To the Funeral Direction completed filled in birds.	Medical	(Check 2 L Medical Exam	iner: On the basis of ex	kamination and/or	leath occured at the time investigation, in my opin edge, death occurred at the	ion, death occurred	at the time, date an	id place, and due to	the cause(s) and manner stated.			
	To the within to the complex c		29b. Signature and title of certifier	200	-M+	29c. Licens			29d. Date signed (M				
U	)		30. Name and address of person who	completed cause of d	eath (Item 23a) (T	ype, Print)	>-000	· (	ctober	27,2010 more			
			Justin M. S	Shaw . 1	ND	Singi	Hospit	al of	Balti	more			
	Sta Registr		31. Date filed <i>(Month, Day, Year)</i> NOV 0 1 2010	32. Registra	r's Signatur	Kel							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Mary Thomas october 2010 • 31 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Baltimore Greater Baltimore Medical Towson 8. Date of Birth
(Month, Day, Year)
Dec. 5, 1927 If Under 1 Year 9. Birthplace (State or Foreign **Funeral** Months 1 M 2 X F Hours Mary Land 82 Director 214-22-1430 Usual Residence of Decedent or 28a-f show notified at 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County Director Lutherville 1 Yes 2 No Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ō "natural", or items 23a or edical Examiner must be permit. Page 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene.
Importants if frem 27 is marked other than "natural", or items 23a any injuy or other traumatic event, the Medical Examiner must bb Funeral USA 21093 1022 Adcock Rd. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11 Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: White 3√ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Carolyn Schlipp Martin Ferris 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Geoffrey Kleintank/ G-Son 21286 <u> 1654 Hardwick Rd. Towson,</u> injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10-30-10 Baltimore, Md. Moreland Mem. Park 21. Signature of Fundal Ser 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner This to the as a conserv. cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Month Pregnant at time of death 5 Other (specify) signed by the and be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, a No 3 Probably 4 Unknown 1 🗌 Yes Completed plnods 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 2 this certificate has 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Division of Vital funeral director, 26. Place of Death (Check only one) Be examiner? Hospital 1 🗌 Yes ER/Outpatient 3 DOA ၉ 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending after death.

Director: Aft Accident Investigation sompleted filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc City or Town, State) 24 hours a Medical 29a. Certifier Certifying Physician: 7p the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: (n/th) basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 14313 2010 30. Name, and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signatu 31. Date filed (Month, Day, Year, State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-34189 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 20°10 Valdivia Jean Mary 6:47 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Cecil 15 Crabbe Court Conowingo 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign Day, Year) 1938 1 □ M 2 🛣 F Days Hours Min. Maryland Director Yrs 218-34-1837 March Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location the Medic of Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 No Cecil Conowingo MD 9 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 15 Crabbe Court 21918 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?...
1 Yes 2 XNo Black, White, etc. ō ģ 1 Never Married 2 Married Maryland 21215-0036 hours after If Yes, Give Year or Dates "natural", 1 Yes 2 X No Specify. 3 Divorced 4 Divorced Specify Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Government Secretary Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ၉ e 1 and 2 should be of Health and Ment John Thomas Crone Mary Ellen Dinan 19a. Informant's Name/Relationship (Type, Print) 19th Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1811 Sparks Drive
Forest Hills, MD 21050 Department of Health a Important: If item 27 is any injury or other tran Richard Valdivia/Son 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Howard This verse ty 4 Donation 5 Other (Specify) 10/1/10 Washington, Medical School 22. Name and Address of Facility Austin Royster Funeral Home 21. Signature of Funeral Service Licenses M00969 3821 14th Street, NW, Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examir ig physician and as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?

1 Yes 2 No Day 5 Other (specify) Pregnant at time of death Month Year been signed by the should be detached 1 ☐ Yes 2 t 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy pade performed death? 2 No Yes 2 No 1 Yes 25. Was case referred to medica Division of Vital the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Tyes 2 No 은 1 Inpatient 2 I ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural (Month, Day, Year) 5 Pending 24 hours after death Funeral Director: A 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Espertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F only one) 🖪 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

32. Registrar's Signature

133 North Bridge Street, Elkton,

Simonson MD

Gloria S
31. Date filed (Month, Day

MD

21921

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AN Certificate of Death 1. Decedent's Name (First, Middle, Last) 0000 2. Date of Death Physician/ Milliams Month Bruce 2010 september 6, Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death a) Shady Grove Adventist Gaithersburg Hospital gomery

9. Birthplace (State or Foreign

Country)

New York 2010 8. Date of Birth **Funeral** 7. Age (In vrs. last birthday) 1 🔀 M 2 🗆 F Months Hours 3 7 1 1 7 1 9 6 6 Director Yrs. 579-02-561 Usual Residence of Decedent ē 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director r 28a-f sh notified September 1X Yes 2 ☐ No MD Montgomery Gaithersburg 10e. Street and Number ö ems 23a or r must be r 10g. Citizen of What Country? Funeral vith 1 8848 Cross Country Place 20879 USA item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. Completed by 1 Never Married 2 Married Yes 2X No If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working I Hygiene. other than " life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private Industry Construction Worker Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental I I and 2 should be fill f Health and Mental item 27 is marked ၉ Johnny B. Williams Mildred S. Simpson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred Williams/Mother 9000 Briarcroft Lane Laurel, MD Department of Healt Important: If item 2 any injury or other 3 once. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Heritage Memorial 9/13/10 Waldorf, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Latney's Funeral Home, Inc. cc0278 3831 Georgia Ave. NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Arrhythmia Ph\_sician/ Cardiac Medical resulting in death) Due to (or as a consequence of) Examiner Stage Renal Diseasa Sequentially list conditions Examiner Due to (or as a consequence of): day, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events attending physician and for use as the burial-transi resulting in death) Last Due to (or as a consequence of) Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Day 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 🕱 No 25. Was case referred to medical eral Director: After this certific filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: 2 🗆 No Other: မ 1 ☐ Inpatient 2 K ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural work?
1 Yes 2 No 5 Pending injury Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, within 24 hours a To the Funeral I Medical 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month. Day. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Rockville Md. 20850 M.D. 9901 Center Drive Emily Gordon

0900 AM

Year

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Ayla Eriel Walker 1335 October 25 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Director 10-11-2010 MD Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show 1. Yes 2 □ No notified Directo MD na Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip-Code ö filed within 72 hours after death with ral", or items 23a or Examiner must be 5112 Ardmore USA Funeral Way 21206 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1X Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Maryland 21215-0036 1 ☐ Yes XXNo Specify. ۾ Specify: 3 Widowed 4 Divorced Black Year or Dates "natural", Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medicai (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) na and Mental Hygiene.
is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) na traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be fir I Health and Mental H Item 27 is marked otl Be Leonard Walker ည Jerikah Bradley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jerika Bradley-Mother 5112 Ardmore Way Balto, Md 21206 other Baltimore. If item 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Pages 1 1 XBurial 2 Cremation 3 Removal from State King Memorial Pk 11-1-2010 ò permit. Page Department of Important: If any injury or once. RANDALLSTOWN, MD 5 Other (Specify) 4 Donation 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** organita Hepatoblastoma /Medical Due to (or as consequence of) Examiner Hemorrhage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to as a consequence of) ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Failure Respiratori resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760, Physician/Medical trematurit IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death Live birth 3 Ectopic pregnancy in the past 12 months? Year Month Day Pregnant at time of death 5 Other (specify) Voc 2 🗌 No 9 Unknown 9 Unk*n*own Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Craculation Completed 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 🗌 No 2 No 1 Yes Division of Vital or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \( \triangle \) Nursing Home \( 5 \) Residence \( 6 \) Other (Specify) Hospital: 2 No 1 Yes 1 SInpatient 2 ER/Outpatient 3 🗆 DOA မ this funeral 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death.

To the Funeral Director; After 1 Natural Pending investigation Injury 1 Yes 2 No 2 Accident filled in by the 3 Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 29a. Certifier 🛮 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar 30. Name and

31. Date filed (Month, Day, Year) **\*\*\* 0 1 2010** 

ddress of person who

omp

DHMH 17 Rev 1/2001

parke

eted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

october 25,2010

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 2010 William Wysling Sr 5:13 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick Frederick Memorial Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year May 14, 1 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Months Days Hours Min. New Jersey Yrs. **Director** 69 T941 144-30-8732 Usual Residence of Decedent "natural", or items 23a or 28a-f show 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No Union Bridge Frederick Marvland 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral U.S.A. 10405 Fountain School Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? 1 XYes 2 ☐ No Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. 1958–63 1 Yes 2 No Specify: Specify. Completed 3 Widowed 4 Divorced White Il Hygiene.
I other than "natura vent, the Me K al E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) master service technician machine mfq. 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mental F marked Ruth Bowles William Wysling and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health : Union Bridge, MD 21791 10405 Fountain School Rd. Shirley Wysling/ wife item 2 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or otl once. 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) County Cremation 10/31/2010 Sykesville, MD 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of Funeral Service Lice (a) 310 Church St. New Windsor, MD 21776 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SPAN AND X.A disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): ng physician and as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: If yes, outcome of pregnancy use 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes Accident Investigation after deat Director: filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours a Funeral L Medical Excertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) uet. MD MDD 70559 0.29.10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 400 w 7th St Frederick MD 21701 31. Date filed (Month, Day, Year) Registrar's Signat State MOY 0 1 2010

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 1115 M Dorothy L. White Medical 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery Social Security Number If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Hours Min Feb 15 1941 North Director 244-64-9115 69 Carolina Usual Residence of Decedent If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County should be filed within 72 hours after death with the Maryland Director 10c. City. Town or Location 10d. Inside City Limits 1 X Yes 2 No DC Washington, 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1445 Otis Place, N.W. 20010 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1X Never Married 2 ☐ Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Medical Coder Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Alexander White Mary Webb and is m 19a. Informant's Name/Relationship (Type, Print) 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1416.44th Street West
Birmingham, AL 35208 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra. Mary A. Phillips/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Oakland Cemetery Nov.3,2010 Birmingham, AL 22. Name and Address of Facility Austin Royster Funeral Home . Signature of Funeral Service Licensee Plutaics Rendon M00969 3821 14th Street, N.W., Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Calitis Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, reading to immediate cause. Enter Underlying Cause (Disease or linjury ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 XNo Month Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed Yes 2 No 1 Yes 2 No 25. Was case referred to medica examiner? B 26. Place of Death (Check only one) Other: 4 \( \text{\text{Nursing Home}} \) 1 \( \text{Residence} \) 6 \( \text{\text{Other}} \) Other (Specify) Hospital 1 Yes 2 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No To the Hospital or Attendin within 24 hours after death.
To the Funeral Director: Af completed filled in by the fu Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 29b. Signature and title of certifier 29c. License number resach ver, MD 10/24/10 D0063703 7600 CARROLL AVENUE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SABYASACHI KAR TAKOMA PARK, M'D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2010 Barks Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10-08050 Robert Joseph Wheeler, Jr. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Da 2005 hrs Medical Examiner Robert Joseph Wheeler, October 19, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Sparrows Point **Baltimore County** 8905 Chesapeake Avenue 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. If Under 1 Year 5. Social Security Number Age (In vrs. last birthday) **Funeral** Months Day: Hours Director 58 218-58-8706 Country) MD 1 X M 2 F Jan. 22, 1952 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Edgemere 1 Yes 2 XXNo "natural", or items 23a or 28a-f show Examiner must be notified at once. within 72 hours after death with the Maryland Baltimore Director 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21219 8905 Chesapeake Avenue Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? ( Specify Yes or No-Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married 1 X Yes 2 No Yes, Give Year 1971 3 XX Widowed 4 Divorced 1 Yes 2 X No specify. Specify. White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed altimore, MD 21215-0036
mit. Pages I and 2 should be filed within 72 ho
partment of Health and Mental Hygiene.
partment of Health and Mental Hygiene and Applicative I filed with unit and the partment of the marked other than unit or other trannatic event, the Nacidical Ex-Social Security Admin. Elementary/Secondary (0-12) College (1-4 or 5+) Computer Technology IT Manager 12 Years 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Delores A. Spivey Robert J. Wheeler, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Parkville, MD 21234 Law) 1821 Berry Wood Road Kristin M. Wheeler (Daughter In 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery Date crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: Entombment Holly Hill Mem. Gdns. 10/23/2010 Middle River, MD 22 Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, 21. Signatur uneral Service Licensee Dundalk Maryland 7922 Wise Ave. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line Medica Death a. Intraoral Gunshot Wound Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician and ed for use as the burial - transit The law requires that the death certificate be executed Sa UNPENDED AMENDED Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown detached 23e. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> 1 Yes 2 No 3 Probably 4 Unknown Completed Records, certificate has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed death? No 2 No ✓ Yes 2 1 Yes 26.Place of Death (Check only one) 25. Was case referred to medical of Vital Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene After this 1 🗸 Yes 2 No 28a. Date of Injury FOUND: 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Subject shot self FOUND: 1 Natural 1 Yes 2 ✓ No Director: / Pending Oct 19, 2010 1949 hrs Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 V Suicide Could not be or Town, State) 8905 Chesapeake Avenue, Sparrows Point, MD (Specify) Home within 24 hours a To the Funeral 1 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated **Medical** 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. October 20, 2010 and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Russell Alexander MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND, ITEM#22perFH, G909, 11/3/2010, WS#5 State of Maryland / Department of Health and Mental Hygiene 0 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Demetria :15 ALI Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Mary land N /A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Fear) 10 0 7 20 10 **Funeral**  Birthplace (State or Foreign Country) 1 □ M 2 F Month Min. **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show 10a. State 10b. County within 72 hours after death with the Maryland the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Balti More 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21205 1611 trenue USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 1 Never Married 2 ☐ Married Black, White, etc. ρ Maryland 21215-0036 Black 1 ☐ Yes 2 🕍 No Specify: If Yes, Give Year or Dates 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) N/A NIA Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) White Donald Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number Grandmother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 N Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signatur of Freeral Service Livensee 22. Name and Address of Facility Harris 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Ph sician/ disease or condition resulting in death) nea Mihute Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death
Unknown Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Septal 24b. Were autopsy findings available prior to completion of cause of death? Lemorrhag 24a. Was an performed?

Yes 2 No certificate 2 🗆 No 1 Tes To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 5 Pending injury 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 36833 D ss of person y Baltino ho completed cause of death (Item 23a) (Type, Print) Greene St 30. Name and addre State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 4:30p Olivia Allen 10 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Future Care Nursing
5. Social Security Number | 6. Sex Home Baltimore 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 F Months Days Hours Min. (Month, Day, Year) Director 225-40-7287 29 97 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 √ Yes 2 □ No MD NA Baltimore 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 3632 Columbus Drive 21215 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 💢 No Black. White, etc. 1 Never Married 2 Married ģ Baltimore. Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5th grade Domestic na Worker Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown 2 Myrtle Norris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Minter-Grandson 4506 Coffee Tree Ct, Pikesville, Md 21208 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Loudon Park 11/5/2010 Baltimore, Md 21. Signature of Funeral Service 22. Name and Address of Facility March F/H West 4300 Wabash Ave. Baltimere. Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SCASO thewschrotic eau disease or condition Medical resulting in death) Me to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records. P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No 2 No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other 1 Yes 2 Julio မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred the Hospital or Attending 5 Pending Natural injury 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie

Registrar
DHMH 17 Rev 7/2009

State

SUITE 203

BATIHOKE, MD 21209

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year,

NOV 03 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MARGARET FILEN ABEL 2010 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** SAGIMORE WARHINGTON EINAL 37-ME N BURNIE Social Security Number Year If Under **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🗷 F Months Days Min. October 24. 1931 215-28-2721 79 Hours Mary land Director Usual Residence of Decedent Page 1 and 2 should be "lied within 12 incurs."
Then of Health and Mental Hygiene.
Thant If item 27 is marked other than "natural", or items 23a or 28a-f show retart if item 27 is marked other than "natural", or items 25a or 28a-f show are the marked of the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Anne Arundel Pasadena 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 106 Brookfield Road 21122 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 Yes 2 No Specify: White If Yes. Give Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 George Howard Kellenbenz Margaret Beatrice Shaffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clyde E. Abel Jr. 2930 Bristol Channel Court, Pasadena, Maryland 21122 Department of Health Important: If item 27 any injury or other the Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗷 Burial 2 🗀 Cremation 3 🗔 Removal from State Glen Haven Mem. Park 10-30-10 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 P in 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one course on each line. Approximate Interval Between Onset and Death mediate Cause (Final Physician/ BNGESTINE disease or condition Medical resulting in death) De o (or as a consequence of): **Examiner** umortif Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): sician and burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant 9 Unknown Pregnant at time of death Other (specify) Month Day Year Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires I within 24 hours after death.

To the Purneral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA . Date of injury (Month, Day, Year) 27. Man of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work? 2 Accident
3 Suicide Investigation 2 🗌 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my kn, which course at the time, date and place, and due to the cause(s) and manner stated. (Check only one 29b. Signatu on who completed cause of death (Item 23a) (Type, Print) Gleu Burnie JV 11ortal

Registrar

State

32. Registrar's Sinnature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ INNIE Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE BALTIMORE MILFORD MANOR NURSING HOME If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Davs Months Hours 0770771917 93 MD 217-09-4520 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10b County 10c. City, Town or Location 10a. State within 72 hours after death with the Maryland Director must be notified 1 Tes 2 No BALTIMORE BALTIMORE MD 10g. Citizen of What Country? 10f. Zip Code ō 10e. Street and Number 23a Funeral 21208 USA 4204 OLD MILFORD MILL ROAD 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14 Race - American Indian Examiner If Yes, specify Cuban, Mexican, Puerto Rican, etc.] Black, White, etc. 9 by 1 Never Married 2 Married ☐ Yes 2X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ▼ No Specify: Specify: 3 ₩ Widowed 4 □ Divorced "natural" WHITE Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) the 12 **SECRETARY** MEDICAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ည UNKNOWN LOUIS SINGER JEANNETTE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 108 BRIGHTSIDE AVENUE, BALTIMORE, MD JUDITH APPLEFELD/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 11/2/2010 HAR SINAI CEMETERY OWINGS MILLS, MD □ Donation 5 □ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) the g 🗌 Unknown Division of Vital Records, P.O. ed by t detach been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s perform 1 Yes 2 No After this certificate Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ပ 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accider 5 Pending 1 Yes 2 No Accident Investigation within 24 hours after death To the Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie erson who completed cause of death (Item 23a) (T 31. Date filed (Month, Day, Year) State

Registrar

Division of Vital Records, P.O. Box 68760, BROWN, Hospital or Attending after death Director:

Baltimore, Maryland 21215-0036

State Registrar

24 hours a

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Khallb Puthawala, MD 5015

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month 4:08 PM Charles Leonard Barker October 30 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center for Hospice Care Baltimore Towson Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 8. Date of Birth <sup>Year)</sup> 1<u>922</u> 1 🗷 M 2 🗆 F Months Days Min. (Month, Day, Feb 22 Maryland Director 215-16-9090 Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits be notified at Director 28a-f 1 Yes 2 No Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 106 Glenmoore Ave 21030 United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō δ 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: "natural" Year or Dates. WWIT Specify: Completed 3 Divorced 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Salesman Wholesale Liquor å 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked o ည Page 1 and 2 should be Edward Leanard Barker Elizabeth Anna Vendouren and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a tem 27 is Ruth Leona Barker /Wife 106 Glenmoore Ave. Cockeysville, MD 21030 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State o **<u>=</u>** ò 1 Burial 2 Cremation 3 Removal from State Nov 02 Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Chesapeake Crematory 2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M01443 Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Exami anding physician and use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy death? Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 1 X Yes 2 □ No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice 1 Inpatient 2 ER/Outpatient 3 IDOA Hospital or Attending Ph 24 hours after death. Funeral Director: After th 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 2 🗆 No Investigation Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifler (Check Cectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. nly one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and titl ertifier 00071287 person who completed cause of death (Item 23a) (Type, Print) State Registrar

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Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 3420 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year September 9, 2010 8:35 AM M Isaac Bristol 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 2524 E. Baltimore Street Baltimore 9. Birthplace (State or Foreign Country) Virginia 5. Social Security Number 7. Age (In yrs. last birthday) Year) 1914 1⊠M 2□F 215-10-1836 96 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD Baltimore Yes 2 □ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21224 USA 2524 E. Baltimore Street 12. Was Decedent Ever in U.S. Armed Forces? 1 52 Yes 2 □ No 1943 If Yes, Give Year or Dates: 1945 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 2□No 1943-1 Never Married 2 Married 1 □Yes 2 No Specify: black Specify 3 Widowed 4 Divorced 1945 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) real estate broker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ballard Bristol Neva Lumpkins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2524 E. Baltimore Street; Baltimore, MD 21224 Gloria Jack - friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Luneral Service Lonal 22. Name and Address of Facility State Anatomy Board Mirector 655 W. Baltimore Street; Baltimore, MD 21201 23a. Part 1. Enter the disease or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat (Final disease or con ition resulting in death) Alzheimer's Disease Natural causes Due to (or as a consequence of): Atrial Fibrillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of) Atrial fibrillaton Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? 1 Yes No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 2 No Hospital: 1 Tes 2 ER/Outpatient 3 DOA 5 Residence 6 ☐ Other (Specify) 1 Inpatient 28a. Date of Injury (Month, Day, Year) 27. Manner of De th 1 X Natural 2 ☐ Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No

P.O. Box 68760, Records, Vital of

and burial-tran attending physician for use as the buria signed by the a has certificate

**Physician** 

Examiner

**Funeral** 

Director

show

death with

72 hours after

Pages 1 and 2 should be filed within one of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, Ita M. Once.

**Physician** 

/Medical

Examiner

Baltimore, Maryland 21215-0036

Director

Funeral

2

Completed

Be

ပ

Examine

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Eval. Inc. out. by routhed at

/Medical

law requires that the death certificate be executed To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Division

Physician/Medical ≥ Completed Be 2 Certification:

29a. Certifier 29b. Signature and title of certifier

3 Suicide

4 Homicide

6 □Could not be determined

and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

T3311/AJY147357 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

October 21,2010 Baltimore MD

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

Medical

31. Date filed (Month, Day, Yes MOY 0 3 2010

Anya Litrak, MD North Caroline St 6001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Colline Marie Busher October 9:35 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital 01ney Montgomery 6. Sex **Funeral** Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🕱 Days Hours August 12, 1929 81 New York **Director** 064-22-4711 Usual Residence of Decedent Show should be filed within 72 hours after death with the Maryland 10a. State 10b. County must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 28a-f 1 Yes 2 No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 3200 Ludham Drive 20906 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian 0 þ 1 Never Married 2 Married Black, White, etc. Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 W Widowed 4 Divorced Specify: White Year or Dates of Health and Mental Hygiene.

item 27 is marked other than "natul
other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Registered Nurse Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Armand Jacques Marguerite Nichols 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Maureen B. Weaver / Daughter Page 1 and 2 7012 Horizon Terrace Rockville, Maryland 20855 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) November 1. Montgomery Crematorium. 4 Donation 5 Other (Specify) 2010 Inc. Bethesda, Maryland Robert A. Pumphrey Funeral Home-Rockville, Inc. 300 W. Montgomery Avenue Rockville, Maryland 20850 21. Signature of Furieral Service Livense MO1607 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician, Decompensated Congestive Heart Failure disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Pneumonia Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Directo (or es a gonsequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and ending physician and use as the burial-transi Respiratory Failure that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☒ No Pregnant at time of death Day Year P.O. been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 Yes 2 No Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To 1 Yes 2 🔀 No Other: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No filled in by the Accident Investigation Suicide Could not be 3 ☐ Suiciae 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) and title of certifie 1001 29d. Date signed (Month, Day, Year) D00 68626 10 31 2010 DC 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year,

Padmaja Bandi, M.D. 18101 Prince Philip Drive Olney, Maryland 20832

32. Registraris Signature

			For	State of Marylan	•			d Mental Hy		0 01	202		
			T = State Registrar		Cer	tificate of L	Death		110g. 140.	0 34	203		
	Physicia	ın/	Decedent's Name (First, Middle, Last)					2. Date of De Month	Day Y	ear	of Death		
	Medic Examin		Bonnie  4a. Facility Name (if not institution, give si	R. Ball	ard	4b. City, Town, or	r Location of D	Octob	er 31 2(	010 2	P <sup>M</sup>		
	LAGITIII	ICI	1502 Patapsco			Balti		odiii	N / A				
	Funeral	Г	5. Social Security Number 6. Sex	7. Age (In yrs. Ia		If Under 1 Year Months Days	If Under 24 I	Hrs. 8. Date of Bin	th c	J. Birthplace (Stat Country)	e or Foreign		
	Director		215-52-2938 Usual Residence of Decedent	62	Yrs.	World Days	Tiodio 10	Min. (Month, Da Dec. 05	.1947 N	Yaryland			
pur	show	   5	10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside	City Limits		
Maryla	28a-f	rect	Maryland N/A		South	Baltimore			1 Å Yes 2 □ No				
with the	Department of Health and Mental Hygiene. Important: if item 223a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Number 1502 Patapsco Street		<u> </u>	10f. Zip Code 2123	30	10g. Citizen of What U.S.A.	10g. Citizen of What Country? U.S.A.				
Jeath	items ier mu	Fun		12. Was Decedent Ever in U.S		Vas Decedent of H f Yes, specify Cuba	ispanic Origin?		American Indian,				
after o	l", or camir	l by	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		Yes 2 No		Black, White, etc.  Specify: White					
-0000 lours after	atura cal E	Completed	3 Widowed 4 Divorced  15. Decedent's Edu	Year or Dates.	16a Decer	lent's Usual Occup	ation						
<b>6 13</b>	an "n Medi	dm	(Specify only highest grad	e completed)	(Give	kind of work done of NOT use retired)	during most of	working	16b. Kind of Busir	less industry			
with:	/giene ner th t, the		12	College (1-4 or 5+) 5	rse		Harbor Ho	ospital					
yland Id be filed	ital Hy ed ott even	To Be	17. Father's Name (First, Middle, Last)					Name (First, Middle,					
	d Mer mark natic	_	Charles W. Bal		1			dred Rober					
Na 2 shot	th and		19a. Informant's Name/Relationship ( <i>Typ</i> <b>Keith R. Ballard</b> (B)	rother)					er, City or Town, State Glen Burnie		d 21061		
1 and	item item other		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of		Date	20c. Location - Ci		<u>u 21001</u>		
Page	nent o		1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	terrioval from otate	emetery, crer intic Cr	natory or other place ematory		. 1, 2010	Glen Burnie	e. Marvlan	d		
Darunnor permit. Page 1	Departr Importa any inju		21. Signature of Funeral Service License		/ 22	. Name and Addres	ss of Facility	McCully-Pol	vniak Funera	al Home P.			
<u> </u>			Just IT	HARIN/	13	U Last Fort	Avenue,	Baltimore,	Maryland 2.	1230			
			23a. Part 1. Enter the disease, or compli shock, or heart failure. List only one Immediate Cause (Final	cations that caused the death cause on each line.	n. Do not ente	er the mode of dyin	g, such as card	diac or respiratory an	rest,	Approxin Interval E	Retween		
	ysician/ Medical		disease or condition resulting in death)	e cause on each line.  DIABETE  Due to (or as a consequ	55/	1211	TUS,	17PE		Onset an	42		
E	caminer			HYPERT		1001		•		19	92		
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  Due to (or as a consequence of):										
See See See See See See See See See See	ınd transi	xam	Cause (Disease or linjury that initiated events tresulting in death) Last  Due to (or as a consequence of):										
e exe	physician and the burial-transit	edical Examiner	resulting in death) Last	Due to (or as a consequ	ence o():								
cate b	physi s the b			l									
Sertifi 6	inding use at	Completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnar	псу	1			23d. Date of	of delivery			
death o	e atte	sicia	in the past 12 months? 1 ☐ Yes 2 🗖 No	1  Live Birth 2 Feta 4 Pregnant at time of d 9 Unknown		Other (specify)			Month	-	Year		
it the	by the	Phy	9 Unknown  Part II. Other significant conditions con		ulting in the u	nderbing cause si	uan in Dart I						
es tha	signec I be d	d by		HOLESTER		nderlying cause giv	veiriii rait i.	23e. Did to	obacco use contribu	Te to the cause o			
e law requires	been should	letec		1 2				24a. Was	1	re autopsy finding			
e law	e has	dmc						— autor	psy pric	or to completion on the state of the state o	of cause of		
<b>.</b>	tificat tor, pa	Be C	25. Was case referred to medical			26. PI	ace of Death (	1 \(\simeg\) Yes Check only one)	2 No 1 L	Yes 2 No			
VICAL	iis cer direc	10 B	examiner? 1  Yes 2 No	ospital:	ER/Outpatier	Othe	er.	1/	dence 6 Other	Specify)			
o de la	fter th		27. Manner of Death 1. ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injun work	y at	28d. Describe h	now injury occurred				
Attendir	death tor: A the f	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	00- 81			Yes 2 ☐ No	_					
lorA	Direct Direct Jin by		4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify,		eet, factory, office		City or Tou	Street and Number o vn, State)	or Rural Route Nu	m <i>ber</i> ,		
Spita	within 24 hours after death.  To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physic	cian: To the best of my knowle	edge, death o	occured at the time	, date and plac	e, and due to the ca	use(s) and manner a	as stated.	*****		
the H	hin 24 the Ft nplete	Mec	only one) 3 L Certifying Nurse	er: On the basis of examination Practioner: To the bast of my	and/or invest knowledge, o	leath occurred at th	e time, date and	red at the time, date a d place, and due to the	and place, and due to e cause(s) and mann	the cause(s) and er as stated.	manner stated		
70	20 Sol		29b. Signature and title of certifier	9/1/1		29c. License	e number	-,9	29d. Date signed (A	Month, Day, Year)	2011		
	0		30 Name and address of person who co	moleted cause of death /Item	23a) (Type 5	Print) —	0023	1/1	1001276	DI-IC /			
	10		Michael  30. Name and address of person who co  RicHARD F	ISHEIZ CR	ATU	TOWER	5 6	LEN BL	PNIE	MDZ	106		

Registrar

31. Date filed (Month, Day, Year) NOV 0 3 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 2010 Year OCT 31 Bauerlien 9:30P Robert James Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Carroll Westminster Social Security Number Birthplace (State or Foreign Country)
 MD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 7 – 13 – 1935 1**X** M 2 □ F 75 215-32-8460 Yrs Director Usual Residence of Decedent 28a-f shov 10b. County 10a. State notified at 10c. City, Town or Location 10d. Inside City Limits Director Carroll MD Westminster 1 ☐ Yes 2 No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be 23a Funeral 2416 Salem Bottom Rd. 21157 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White "natural", Completed 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Tool Machinist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Bauerlien Lillian Turfle Casper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hazel M. Bauerlien-wife Salem Bottom Rd., Westminster, MD 21157 2416 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗆 Removal from State Salem United Cem 11/4/10 Westminster, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fletcher Funeral Home 21. Sign sure of Funeral Service Licensee howas 254 E. Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical Examiner resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury Due to (ur as a consequence of,: the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 2 \ No 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 -No 1 Yes Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 🗆 No Other: INPATION 1 Tes 은 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending 1 🗌 Yes 2 🗌 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signat re and title of certifier 29c. License number 29d, Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

(CIIGOTH, STUMPER)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's

Amend 20b-c, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 20 | 0 For State Registrar 34205 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ John hy Boston 14:39 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore University of Manyland Medical Center If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🛛 M 2 🗆 F 217-68-3660 56 3/9/19 Director MDUsual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County the Maryland 10c. City. Town or Location Director 10d. Inside City Limits MD Baltimore 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2401 E Biddle St 21213 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, δ 1X Never Married 2 ☐ Married 1 ☐ Yes 2 🙀 No If Yes, Give Year or Dates. Black, White, etc. Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Je filed with. The Hygiene. Ther than "r 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 7th Private Contractor College (1-4 or 5+) Landscape permit. Page 1 and 2 should be filed wir Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ٩ John Boston Sr Rosie Goodman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21213 Karen Garris 8420 Kings Ridge Rd, Apt-B4Parkville, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date The 20c. Location - City or Town, State 1 

Burial 2 Cremation 3 

Removal from State Ardent Cremation 11/6/2010 Baltimore, MD 4 ☐ Donation \*5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Phillip A Weatherford E Oliver St Baltimore, MD 21213 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph sician/ pheumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions. ne if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? renal fallure 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? Yes 2 No death? 1 Yes Be ( 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Hospital ျပ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Cther (Specify, 27. Manper of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Matural (Month, Day, Year) 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Defining Physician. To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Defining Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) and two 1942468384 Oct. 18, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South Greene Street Baltimore, MD 212/1 31. Date filed (Month, Day, 32. Registra State Registrar

ORIGINAL

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene / | | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER DAVID BLITZ 2010 7:00P Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b City Town or Location of Death 4c. County of Death BALTIMORE SEASONS HOSPICE@NORTHWEST HOSPITAL RANDALLSTOWN 5. Social Security Numbe If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral Hours Min Months b7/10/1918 212-30-8130 92 POLAND. Director Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location with the Maryland 10d. Inside City Limits Director MD BALTIMORE **BALTIMORE** 1 Yes 2 X No 10e Street and Number 10f. Zip Code 9 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 21208 FARMHOUSE COURT USA death v Was Deceud. Armed Forces? Ves 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2XXMarried Maryland 21215-0036 within 72 hours after al Hygiene. d other than "natural", o event, the Medical Exam If Yes, Give Year or Dates 1 Yes 2 No Specify: WHITE Specify. Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) & DIE MAKER <u>MANUFACTURING</u> Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ UNKNOWN UNKNOWN NOAH BLITZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROSE BLITZ/WIFE FARMHOUSE COURT, BALTIMORE, MD 21208 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) SINAI CEMETERY 10/31/2010 OWINGS MILLS, MD 22. Name and Address of Facility SOL LEV 8900 REISTERSTOWN ROAD, LEVINSON & BROS., QAD, PIKESVILLE, INC. MD 21208 23a. Part 1 Inter the disease, or complications that caus of the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Interval Between Inset and Death Immediate Cause (Final Physician/ LUSC disease or condition Medical resulting in death) to (or as a consequence of) Examiner Sequentially list conditions Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi and that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Year Pregnant at time of death 9 Unknown 9 Unknown ate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 Yes 2 110 Yes Be 25. Was case referred to medica completed filled in by the funeral director, 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No မ 4 ☐ Nursing Home 5 ☐ Residence 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury\_at Certificate: 28d. Describe how injury occurred Natural 5 Pending iniury s after death. 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check . License number 29d. Date signed (Month, Day, Year) 7004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOTOLO

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month,

3 2010

. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ october 28 2010 ear SUSAN BLUMENFELD Р 2:55 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death BALTIMORE 7934 STEVENSON ROAD BALTIMORE 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours Min 09/05/1942 **Director** 215-40-2474 68 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD **BALTIMORF** BALTIMORE 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7934 STEVENSON ROAD 21208 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates WHITE 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) BILLING COORDINATOR **MEDICAL** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ HAROLD WOLFF NATALIE MAXON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7934 STEVENSON ROAD, BALTIMORE, MD 21208 LLOYD BLUMENFELD/HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State HAR SINAI CEMETERY 10/29/2010 OWINGS MILLS, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., 21. Signature of Funeral Service 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Mary disease or condition resulting in death) years Medical Due to (or as a consequence of): Examiner oue itially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Month Day Year 1 L Yes 2 L 9 Unknown the as been signed by the 2 should be detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by aundice 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 1 Yes After this certificate has been funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No calorie 24a. Was an Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 🗹 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 🗆 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural work?
1 Yes 2 No 5 Pending Accident I Director; / Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined

within 24 hours after de To the Funeral Directo completed filled in by the

State Registrar

Osler Drive Suite 502, Towson, MD 7505 2. Registrar's Signa are

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical

29a. Certifier

(Check only one)

3 🗆 29b. Signature and title of certifie

forman

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D61777

29d. Date signed (Month, Day, Year) 10,28,2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34208 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Douglas B. Bailey Medical otober 2010 7:00 A 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Harford Young At Heart Joppa Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** (Month, Day Days Hours Min Day, Ye 1 🛛 M 2 🗆 F Months 88 **Director** Pennsylvania 204-01-9576 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Essex 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a on event, the Medical Examiner must be by Funeral 355 Hopkins Landing Drive 21221 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 😾 Widowed 4 🗌 Divorced Completed Specify: Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) N/A Supervisor Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Emma Stella Fredmann item 27 is marke other traumatic Paul Dudley Bailey 1 and 2 should f Health and M ttem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 355 Hopkins Landing Drive Essex, Maryland 21221 Donald R. Ford (Guardian) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot Date 1 🔀 Burial 2 🗆 Cremation 3 🗔 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Nov. 03, 2010 Parkville, Maryland Moreland Memorial Park 21. Signature of Funeral Service License 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services-Parkville 8800 Harford Road Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or their failure. List only one cause on each line. Immediate Cause (Final disease or condition ATHEROSCLEROTIC CHRONISCULLE DISEISE Onset and Death

OFR 5 YEARS Ph sician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 24 hours after deatl Funeral Director; 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Lectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number **DOF** 16389 29b. Signature and title of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DEPTID C. VINIARITO, H.D. 1716 HARFORD ROAD SU. JUS FALLSTON HID 21047

DHMH 17 Rev 7/2009

State Registrar

31. Date filed (Month, Day, Year)

32. Registra 's Signature

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, d		SINAL HOSPITAL OF BACTIMORE BACTIMORE CITY N/A  5. Social Security Number 6. Sex 77. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth -14-1937 9. B										db=1 104	E		
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permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiens Important: If item 27 is marked other than any injury or other traumatic event, the Meoone.		21. Signature of Fund	al Service Vicens	- LONATHAM	p. 1				s of Facility	PHIL:	LIPS F	UNE	RAL HOME	, P.A	. •
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physicia the bur	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   Yes 2   Yes 3   Yes 3   Yes 4   Yes 3   Yes 4											204	EARS		
n certific ending use as	an/M	IF FEMALE: 23b. Was decedent pr	regnant	23c. If yes, outcome	of pregnar	ncy death 3	□ Ectoni	c pregnanc	v				23d. Date of de	livery	
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	ysici	in the past 12 mo 1 Yes 2 U 9 Unknown		4 ☐ Pregnant a 9 ☐ Unknown			Other		,				Month	Day	Year
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require been si	leted	TIPUNA	TREMIA							_	1 24a. Was		2 ☐ No 3 ☐ F	ntopsy findir	ngs available
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Attendi r death. ctor: A	Certificate:	2 Accident	Investigation 6 Could not be determined		ry - At hor	ne, farm, s	M street, facto	1 🗆	Yes 2 N		f Location (	Street ar	nd Number or Ru	ral Route N	umher
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e Hosp 24 hor e Fune	Medical	(Check 2 L		sician: To the best of a ner: On the basis of ex e Practioner: To the	kamination	and/or inv	estigation, i	n my opinio	n, death occu	urred at th	e time, date	and place	e, and due to the	cause(s) and	I manner stated.
within 50 th		29b. Signature and titl	le of certifier				25	9c. License	number	,			ate signed (Mont		2010
		30. Name and address		ompleted cause of de	eath (Item	23a) (Type	. Print)	ESDIN					BER TH	1RTYF	WST
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🕕 📗 🕕 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Crystal Marie Babb 10 Medical 2010 :15A 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Seasons Hospice Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🏝 F Months Days Hours (Month, Day, Year) 01/24/1983 Maryland 220-02-8205 27 **Director** Yrs. Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 1329 W. Lombard Street 21223 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Armed Forces?

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1 ☐ Yes 2 ☐ No Day Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ MONALY EMBOLISM 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown Completed ENCEPHALOIATH 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy death? After this certificate 1 ☐ Yes 2 ☐ No Yes **Division of Vital** funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No ٩ Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 X Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending work 24 hours after death. 1 🗌 Yes 2 🗌 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 | Medical Examiner: On the basis of examination and/or investigation, in rify opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) MD 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 717 HAMMONAS BALTIMORE 31. Date filed (Month, Day, Year) State NOV 0 3 2010 Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

CIVIII BIOGGOII		1- For State Registrar	State	of Maryla	ınd / l		nent of cate of		nd Men	ıtal Hyg		eg. No.	201	0 3!	421
Physiciar Medical Examin	n/	1. Decedent's Name (First, M		•		_					Date of Dea Month	th Day	Year	3. Time of I	
Medical Examin	ei	Ervin S. ] 4a. Facility Name (if not insti	_		mber)		41	City Town	or Location		October 2	26, 201	O County of De	0600 h	irs
	4a. Facility Name (if not institution, give street and number)  Maryland General Hospital  4b. City, Town, or Location of Death Baltimore								or Bouti		10.	N/A	dui		
Funeral Director		5. Social Security Number	6. Se	1		n yrs. last bi	rthday)	If Under 1 Ye			8. Date of Bir	rth (MM/D	D/YYYY) 9.	Birthplace (State	e or
Director	-	214-62-7027 Usual Residence of Deceder		M 2 F	_	56	Yrs.	INCHUIS DO	193 110013	o IVIII1.	01/2	7/19		O	MD
any	Ì	10a. State 10b. County 10c. City, Town or Location												10d. Inside	City Limits
land f show	اق	MD	N/A	4				Balt	imore	9				1 X Yes	2 No
th the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number	** ' 7 7	_				10f. Zip Code			1	0g. Citize	en of What C	ountry?	
with th	<u>a</u>	2361 Druid  11. Marital Status	HITI	12. Was Dec			13. Was	2 2 Decedent of H	1217	nin? ( Spec	ify Yes or No		S.A.	erican Indian, B	Black
death or iten	Funeral	1 Never Married 2	Married	Armed Fo			If Yes	, specify Cuba	an, Mexican	, Puerto Rio	can, etc.)		White, etc		ilder,
rs after ural", miner	잙	3 Widowed 4 15. Decedent's Education (		If Yes, Give Year or Dates:	Too 2 Ito specify.								Specify: B1		
72 hourn n "natu	eted	Elementary/Secondary (0-		College (1-		ted) Toa.	during mos	t of working lif	ation (Give I e. DO NOT	kind of worl use retired	k done )	16b. Kir	nd of Busines	ss/Industry	
5-0036 lied within 7 Hygiene. I other than the Medica		11th Grade					Bar	tender	r			Sug	ar Hi	.ll Tav	zern
215-( be filed v ntal Hyg rked oth ent, the	וכ	17. Father's Name (First, Mid	. ,								irst, Middle, N	Maiden Si	urname)		
212 ould be ould be a Ment it ever		Stanfeild  19a. Informant's Name/Relati				19	b. Mailing A	ddress (Stre	Lu eet and Num	Cill ober or Rura	e Whi	te nber, City	or Town, St	ate, Zip Code)	
MD  nd 2 sho alth and m 27 is aumati	1	Curtis Bro	gdon	(brot	her	) 4	126 (	Sladd∈	en Av						
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiens in Mental Hygiens in Innovariant: If tiem 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	- 1	20a. Method of Disposition 1 🗶 Burial 2 🔲 Crema	tion 3	Removal fro	m State		of Disposition of Disposition	on (Name of ce place)	emetery,	D	ate	20c. Lo	cation - City	or Town, State	
Itim iit. Pag urtment ortant	-	4 Donation 5 Other 21. Signature of Funeral Serv		99 . 4		King	Mem.	Park	S of Facility	11/0	2/10	Ва	<u>ltimc</u>	re,MD	
Balti permit. Departm Importa injury o	K	Dutuch	V. H	Ville	in	W	212	seph	Hul B	rown Sn A	Jr. ve.:B	Fun	eral imore	Home <sub>2</sub>	' <u>}</u> 17
Physician /Medical		<ol> <li>Part I. Enter the disease failure. List only one car</li> </ol>	or compli	cations that ca	used the	death. Do n	ot enter the	mode of dying	, such as ca	ardiac or re	spiratory arre	est, shock	c, or heart	Approxima Between 0	ite Interval
Examiner		Immediate Cause (Final diseasor condition resulting in death		Hyper	tens	sive A	thero	sclerot	tic Ca	ardiov	vascu1	ar D	isease	De	
		Sequentially list conditions,	b	de to (or as a t	Jonseque	stice or).									
in en		if any lineding to immediate cause. Enter Underlying Cau	se	kie to (ur as a c	oneequ:	ines ofly									
ed sit	- Ya	(Disease or injury that initiate events resulting in death) La	-	ue to (or as a	onseque	ence of):									
). Box 68760, the death certificate be executed by the attending physician and ched for use as the burial - transit  Physician/Medical Examiner	5	X UNPENDED	<b>−</b> 1 d	AMENDED	23a	.27 pc	er me	g909 1	1-10-	10 vt					
760, cate be physicic he burit		F FEMALE:		23c. If yes, or				6,00, 1		10 46		23d. [	Date of delive	erv	
Box 687: death certification at the attending poor for use as the oversion of	2	3b. Was decedent pregnant in past 12 months?	the .	1 Live bir	th	of dooth	Fetal		Ectopic	pregnancy			lonth	•	Year
Box e death the atte		1 Yes 2 No 9	Inknown	g Unknov		, or dodding	Other	(Specify)							
of Vital Records, P.O. Box 6876 ing Physician: The law requires that the death certificat After this certificate has been signed by the attending ph. funeral director, page 2 should be detached for use as the on: To Be Completed by Physician/M		Part II. Other significant con	ditions	contributing to	death bu	t not resulting	g in the und	erlying cause	given in Par	rt I.				to the cause of o	
Division of Vital Records, P.O tat or Attending Physician: The law requires that it as after cleath.  *I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacler in the funeral director. Page 2 should be detacled in the funeral director.			<u> </u>								1 Yes 24a. Was a			obably 4 🗸 L	
(ecords, The law require ate has been signage 2 should b											autops perfor	sy		autopsy findings completion of c	
al Re an: The rrtificate tor, page	۱,	5. Was case referred to med	cal		_			26 Place	e of Death (	Check only	1 Yes 2	No No	1 🗸		No
Vita hysicia this ce al direct	)	examiner? 1 ✓ Yes 2 No	Но	spital: 1 In	patient	2 🗸 ER/0	utpatient 3		Other:	Nursing H		Residence	e 6 Oth	er:	-
		7. Manner of Death  1 X Natural 5 Pe	- 41 -	28a. Date of (Month, I	Injury Day,Year)	28b.	Time of Injur		ry at Work?		d. Describe h	ow injury	occurred		
Division o ital or Attending urs after death. ral Director: After illed in by the fune ertification:		2 Accident In	nding estigation	28e Place	of Injury	- At home fa	rm street f	actory, office b	Yes 2 1		Location (S)	troot and	Number of C	Dural Davis Num	ahas City
Division of Vital Receptal or Attending Physician: The Iours after death.  reral Director: After this certificate I filled in by the funeral director, page Certification: To Be Corr			ould not be termined	(Specify)	o,o., y	TR TIOTHO, TO	,,,, on cot, 1	dotory, office t	Januariy, etc.	. 201.	or Town, St		Number of F	Rural Route Num	iber, City
25 2 2 7		9a. Certifier 1 Certifying	Physician	n: To the best	of my kno	owledge, dea	th occurred	at the time, da	ate and plac	ce, and due	to the cause	e(s) and n	nanner as sta	ated.	
To the He within 24 To the Fe completel	2	9b. Signature and title of cert	a	On the basis of ind manner sta	examina ted.	tion and/or ir	ivestigation	in my opinion		urred at the	time, date a				
		110 A.	0	NID				O.C.I			-	_	er 27, 201	onth, Day,Year)	
	3	0. Name and address of pers	on who co	mpleted cause	of death	(Item 23a)		L							
		Melissa Brassell, Mi	) Ass	istant Medi	cal Ex	aminer	111 Pen	n Street, B	Baltimore,	, MD 212	201				
State Registrar		1. Date filed (Month, Day, Yea NOV 032	010	32. Regi		grature	arke	9							
		1101 006		100	/	7		_			-	_	<del></del>		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Novembe Inna 1,2010 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1 M 2 K Days Hours **Director** 80 MD <del>212-26-9878</del> 06/10/1930 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar process. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director YXYes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country 3128 O'Donnel 21224 Street U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼ No If Yes Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 25
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify 2 Specify: White 3 Widowed 4 N Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) K-Mart 10 Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be ၉ John Lanoch Frances Rewers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3128 O'Donnel St., Baltimore, MD 21224 Bonnie Nixon 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 11/3/10 | Glen Burnie, MD Atlantic Crem. 21. Signature of Funeral Service License 22. Name and Address of Facility 2829 Hudson Street Baltimore, MD 21224 Skarda F.H. 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final inflammator Sustemic **Physician** Syndrane response disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Mesenteric 15chemia if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events use as the burial-tran resulting in death) Last Due to (or as a consequence of): physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Year 4 Pregnant at time of death Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 4 Unknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 🗌 No certificate Yes 2 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Other: 4 \( \text{Nursing Home} \) 1 \( \text{Specify} \) 1 ☐ Yes 2 XNo 1 npatient 2 ER/Outpatient 3 DOA မ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1X Natural 5 Pending investigation s after death.

I Director: Aft
id in by the fu Accident 1 Yes 2 No 3 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

Division of Vital Records, P.O. Box 68760 e Funeral I within 2

> State Registrar

one)

29b. Signature and title of certifier

ente levo 31. Date filed (Month, Day, Year)

EM.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

T5670

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

November 1,2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day\_30 Physician/ October Kunti Devi Comar 2010 12:27 PM M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery 12436 Bacall Lane Potomac Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 1 🗆 M 2 😾 F Months Hours June 1/20°, 19920 India 90 Director 455-55-3018 Usual Residence of Decedent 28a-f shov iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Potomac 1 🗌 Yes 2 💢 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12436 Bacall Lane 20854 India death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc ģ 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 ☐ No Specify: 3 ♥ Widowed 4 □ Divorced Specify: Asian "natural" Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72. h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Amar Kaur Puri K.C. Madan permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12436 Bacall Lane, Potomac, Maryland 20854 Man M. Comar - Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimre Washington Crem. 11/01/2010 Laurel, Maryland Signature Funeral Service Licens 22. Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland MO1283 Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Ozset and Death Physician Atherosclerotic Cardiovascular Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 10 years Hypertension Sequentially list conditions, Examine Olie to (or as a nonsequence of) It any leading to inmediate cause. Enter Underlying Cause (Disease or iinjury that initiated events sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the 33 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for Month Pregnant at time of death 5 Other (specify) 9 Unknown s been signed be should be deta Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed Failure to thrive 2 XNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 2 X No 1 ☐ Yes 2 ☐ No Yes\_ s after deau... al Director: After this ce.u... Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) 1 Yes 욘 2 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 🏋 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending ☐ Accident ☐ Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours af

To the Funeral Di

completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one 3/ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D28656 Nov. 1, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ravi Passi MD, 15245 Shady Grove Rd, #130, Rockville, Maryland 20850 31. Date filed (Month, Day, Year)
NOV 0 3 2010 32. Registra's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Join Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or ocation of Death 4c. County of Death **Examiner** P 1) Town last birthday) If Under If Under 24 Hrs. 9. Birthplace **Funeral** 19 1 🔀 M 2 🗆 F Months Hours Country Director Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at 10a. Director 1 X Yes 2 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral items 23a r death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White ō þ 1 X Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates Specify "natural", Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working jite. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) than y/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. alesman Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Ma permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked c any injury or other traumatic eve ဂ Informant's Name/Relationship (Type, Koxanne Mothe arriage 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 🔀 Burial 2 🗌 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Vaughn C Green 5151 Baltimore Nationa 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death leedining Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due (or as a consequence of) Examiner Nemi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) and I-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last attending physician ( I for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tyes 2 No 3 Probably Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy this certificate After this certification funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Yes 2 🔲 No ER/Outpatient 3 DOA ြို 1 Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 5 Pending Vatural within 24 hours after death.

To the Funeral Director: All completed filled in by the fu 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifie ed cause of death (Item 23a) (Type, Print) and address of person 32. Registrer's Signature State 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Alfonse V. Crisitello October .2010 5:48 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Baltimore Towson 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 X M 2 D F (Month, Day, Year) 10/28/1930 New Jersey Director 135-22-4190 80 an "natural", or items 23a or 28a-f shov Medical Examiner must be notified at within 72 hours after death with the Maryland 10a, State 10h. Counts 10c. City, Town or Location Director 10d. Inside City Limits MD Talbot 1 🗌 Yes 2 💢 No Easton 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 29725 Sullivan Drive 21601 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Black, White, etc. 1 Ves 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔽 No Specify: Completed 3 Widowed 4 Divorced White 1947-49 Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) jiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Truck Driver Transportation other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental Fisher is marked of permit. Page 1 and 2 should be Department of Health and Menta Important. If item 27 is marked any injury or contract. 2 Anthony Crisitello Anne Carpentieri 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeanette Crisitello, Wife 29725 Sullivan Drive, Easton, MD 21601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State Restland Memorial Park 11/04/2010 East Hanover, NJ 21. Signature of Fur Harman 22. Name and Address of Facility Tuttle Funeral Home rvix e Licensee 272 State Rt. 10 West, Randolph, NJ07869 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) wew Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 2 No Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been signated by page 2 should b Completed 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical director 26. Place of Death (Check only one) Hospital 2 PNo Other: 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No ieral Director: A filled in by the f Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N Charl towson KUMA 701 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 34216 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day October 26, 2010 1613 hrs Medical Examiner Clark 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Sinai Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** oreign Days Hours Director Country) MD bЗ 31 92 1X M 2 F 18 216-35-9706 Usual Residence of Deceden 10d. Inside City Limits any 10c. City. Town or Location 10a. State 10b. County Baltimore ral", or items 23a or 28a-f show iner must be notified at once. MD NA 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ā U.S.A. 21207 4005 Barrington Road Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc 1 X Never Married 2 Married 2 X No Yes If Yes, Give Year 3 Widowed 4 Divorced 1 Yes 2 X No specify: Specify: Black ğ r Dates Pages I and 2 should be filed within 72 hours i tent of Health and Mental Hygiene unt: If item 27 is marked other than "natura r other traumatic event, the Medical Esamir 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Baltimore City Laborer NA 12th grade 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Donte Clark Be Michelle Gasque 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Md 21207 4005 Barrington Road, Ann Clark-Grandmother 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 1/2/2010 Arbutus, 4 Donation 5 Other Specify. Arbutus Memorial 21 Signature of Funeral Service Licen 22. Name and Address of Facility March F. H. West 4366 Wabash est Ave, 21215 Baltimore, Md the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line √Medical Death a Multiple Gunshot Wounds Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and tran: Physician/Medical the attending physician ed for use as the burial -UNPENDED X AMENDED #17perFH,G909,11/3/2010,WS requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Year Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, P.O. þ 1 Yes 2 V No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy After this certificate has death? performed? ✓ Yes 2 No 1 V Yes 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital æ Other Nursing Home 5 Residence 6 Other: 1 V Yes 2 No 28a. Date of Injury FOUND: 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: Subject shot within 24 hours after Ceath.

To the Funeral Director: A FOUND: Natural 5 Pending 1 Yes 2 ✓ No Oct 26, 2010 1520 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) 3500 Carsdale Ave, Baltimore, MD the Hospital (Specify) Local Street 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 😿 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) October 27, 2010 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 1/2001 OCME 2006

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER JACK R. COOPER 2010 12:00 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST CENTER TOWSON BALTIMORE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Months Hours 1 □XM 2 □ F Min. (Month, Day, Year) 11/8/1925 Country) N.J 84 Director 146-18-8461 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. Count 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 10d. Inside City Limits N.J. N/A Ocean City 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 218 Ocean Road 08226 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. 2 1 Never Married 2 Married 1X Yes 2 No Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic access. 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates. WWII 3 Widowed 4 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Finance **GMAC** Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Jack P. Cooper Ella Haig 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emma K. Cooper/Wife Ocean City, NJ 218 Ocean Road 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State Westfield Friends 11/1/2010 4 ☐ Donation 5 ☐ Other (Specify) Riverton, NJ 21. Signature of Funeral Service Licensee MOO217 22. Name and Address of Facility The Johnson Funeral Home, 8521 Loch Raven Blvd. Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician PULMOUS CELL disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury See to (or se a consequence or) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) Day Yes 2 □ No ate has been signed by the page 2 should be detached 9 Unknown 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed this certificate 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) 2 No Other: ျ 1 🗌 Yes 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) funeral Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending 1 Yes 2 No Accident Investigation after deat Director: n 24 hou.. the Funeral Dire.. ما filled in by th Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 within 2 To the I Certifying, Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) 71040 2010 Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, 32. Registrar's Signature

State

Registrar

03

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar		State of Ma	aryianc	•	tificate of				Reg. N	001	0	21210
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Baltimore, Maryland 21215-0036	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral S	Service Lense	ee	,	22	. Name and Addr	ess of Fac	cility And	atomy G	ift	s Reg	istr	У
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Box 68	To the Hospital or Attending Physician: The law requires that the death certificating 14 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use a	Physician/N	23b. Was decedent pregr in the past 12 month 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	ant		2 Fetal	death 3	Ectopic pregnal Other (specify)	псу				Mon		Day Year
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o uc	ttending I death. ctor: After y the funer	icate	2 Accident	Pending Investigation	(Month, Day	i, Year)	injury		rk? Yes 2	_		·			
Division of Vital Records,	Il or Atte after de Directo d in by th	Certificate:	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	28e. Place of Injubulding, etc	ry - At hor c. (Specify)	me, farm, str	eet, factory, office	,		28f. Location ( City or To			r or Rura	l Route Number,
	To the Hospital or Attenc within 24 hours after deatl To the Funeral Director: completed filled in by the	Medical	(Check 2 D	ledical Exami	ician: To the best of ner: On the basis of e e Practioner: To the	xamination	and/or invest	tigation, in my opin	nion, death	n occurred at	the time, date	and place	ce, and due	to the ca	use(s) and manner stated
	To the within To the Compl	Σ	29b. Signature and title o	Certifier		best of frig	Knowledge, V	29c. Licer	se numbe	er			ate signed	(Month,	Day, Year)
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Ī	Sta Registr		31. Date filed (Month, Day	( Year)	32. Regist	ar's Signat	ure								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Armand L. Caron Physician/ October 29, 2010 10:15 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Hospice Casey House Rockville Montgomery If Under 1 Year | If Under 24 Hrs. . Social Security Number . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 . F 79 Months Days Hours Min 027-26-9625 Director 1931 Massachusetts Usual Residence of Decedent shov 10a. State 10c. City, Town or Location with the Maryland must be notified at 10d. Inside City Limits Director 28a-f Maryland Montgomery 1 X Yes 2 No Rockville 10e. Street and Number 0 10g. Citizen of What Country? items 23a Funeral 1602 Bradley Avenue 20851 United States Page 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. "natural", or item edical Examiner n 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Yes : 2 No 3altimore, Maryland 21215-0036 теs, Give Korea Year or Dates. 1 Yes 2 No Specify: Specify: White 3 ☒ Widowed 4 ☐ Divorced marked other than "natur matic event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) U.S. Government Position Classification Specialist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H 2 Armand Laurier Caron 27 is marked Adrienne Louise Fontaine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul F. Caron/Son 44780 Ashlar Terrace #304, Ashburn, Virginia 20147 Department of Health Important: If item 27 any injury or other to once. 20b. Place of Disposition (Name of Gate of Heaven Cemetery Communication of Cemetery 20a. Method of Disposition November 6, 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗀 Removal from State Silver Spring, Maryland 2010 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Ave., Rockville, MD 20850-2805 M00198 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shool, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death B Cell Lymphoma Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or imjury that initiated events Examiner Due to (or as a consequence of): Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Completed by Physician/Medical 09/89 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box ( 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Day Month Year Pregnant at time of death 1 Yes 2 No the 9 Unknown P.0. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy I or Attending Physician: The lafter death.

Director: After this certificate h performed? Yes 2 🖾 N 1 Yes 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one examiner? Certificate: To 1 Tes 2 🔀 No Other: 4 □ Nursing Home 5 □ Residence 6 ☒ Other (Specify) Hospice 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛚 Natural injury 5 Pending work 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State To the Hospital within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 E Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) R143201 October 30, 2010

State

Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who Debrah Miller, (

31. Date filed (Month, Day, Year)

CRNP

2010

6001 Muncaster Mill Road, Rockville, Maryland

ed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ John V. Cannaliato 2010 9:50 P October Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death County of Death
Baltimore Examiner Glen Arm 11501 Long Green Pike 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Jan. 24,1931 5. Social Security Number If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Days Hours Baltimore, Maryland Months 1 XM 2 - F 79 Director 214-26-6262 Usual Residence of Deceden 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State by Funeral Director notified 28a-f Maryland Baltimore Glen Arm 1 Yes 2 No 10g. Citizen of What Country?
United States 10f. Zip Code 능 must be 21057 23a 11501 Long Green Pike al Hygiene. d other than "natural", or item: event, the Medical Examiner r Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore City Traffic Sr. Investigator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Page 1 and 2 should be file ment of Health and Mental I marked မ Genevieve Cannaliato William J. Grierson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) S permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is 11501 Long Green Pike Glen Arm, Maryland 21057 Alvera M. Cannaliato (Spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Dulaney Valley Memorial 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Nov. 06,2010 Timonium, Maryland Donation 5 🗆 Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility any ir Etwans Fureral Chapel & Cremation Services—Parkville 8800 Harford Road Parkville, Maryland 21234 23a. Part 1. Per he disea e, or complications that caused the death shock, it heart fallure. List only one caus, on each line. op not ent the mode of lying, such as cardiac or respirato arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): physician a s the burial-1 Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use control to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 🗌 Yes 3 Probably 4 Unknown Division of Vital Records, 245. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy performed Yes 2 25. Was case referred to 26. Place of Death (Check only one) Certificate: To Be examiner? Hospital Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5XX Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Natural injury 5 Pending 1 ☐ Yes 2 ☐ No n 24 hours arter to be Funeral Director; A Investigation Accident 3 Suicide 4 Homicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examination of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurs within 2 To the 29c. License number re and title of certifie and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Mis

, RKIS

1505 OSLER Die. #

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			State of Maryland / Department of Health and State  1- For State Registrar  Certificate of Death	Mental Hy	•	34221
			Decedent's Name (First, Middle, Last)	2. Date of De	ath	3. Time of Death
_	Physici /Medio		Augusta Mae Curry	Month 10	28 2010	9:06P M
	Examir		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Deat	h	4c. County of Dea	th
			Harford Memorial Hospital Havre de Grace		Harford	
	Funeral		5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  1	(Month, Da		thplace (State or Foreign ountry)
	Director		Usual Residence of Decedent	Januar	y 9,1923	Maryland
0	72 hours after death with the Maryland naturel; or items 23s or 28s-f show iteal Examither must be notified at	ō	10a. State   10b. County   10c. City, Town or Location   Havre de Grace			10d. Inside City Limits 1 ☐ Yes 2 💆 No
0	the N	ect	10e. Street and Number 10f. Zip Code		10g. Citizen of What Co	ountry?
210	3a or	Funeral Director	128 Cooley Mill Rd 21078		USA	•
S	death ms 2	era	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S Armed Forces? If Yes, specify Cuban, Mexican, Puer	Specify Yes or No	14. Race - Ame	
· · ·	or its		Armed Forces?  1 Never Married 2X Married  1 Yes, Specify Cuban, Mexican, Puer 1 Yes, 2X No 1 Yes, Sive	to Hican, etc.)	Black, White Specify White	
003	ure!	d by	3 Widowed 4 Divorced Year or Dates:			
5	nat Trail	ete	15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired)	rking	16b. Kind of Business	/Industry
0 2	than the	Completed	Elementary/Secondary (0-12) 12 College (1-4or 5+) Business Owner		Construct	ion
/ 6	Hygi other	BeC	<u> </u>	me (First, Middle	, Maiden Sumame)	
× 2	Ald be Aenta rked tic ev	ToB	Berlin Blakeley Elizabe	eth Smy	th .	
0/28/10 Marvland 21215-0036	should have	0	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Relationship)			
0	and 2 ealth m 27 i		Betty Phipps / Daughter 629 S. Rogers St,			
A /	permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Hygiene.		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or	
Ë	artme ortani injury		4 Donation 5 Other (Specify) Rock Run Cemetery 11/2, 21. Signature of Funeral Service Eigensee		Havre de	
_ 4 B	Dep de de de de de de de de de de de de de		21. Signature of Funeral Service Licensee Tarring—Cargo Fu	unera⊥ . Aberd	Home, P.A leen, MD 2	1001
S	46.		23a. Part1. Enter the discrete, or complications that caused the death. Do not enter the mode of dying, such as cardial shock, or heart failure. List only one cause on each line.			Approximate Interval Between
7	Physician	(0 - i	Immediate Cause (Final disease or condition  ASPIRATION  PNEUMONIA			Onset and Death
	/Medical		Immediate Cause (Final disease or condition resulting in death)  a. ASPIRATION PNEUMONIA  Due to (or as a consequence of):  RESPIRATORY FAURE			
3	Examiner		Exquentially list conditions. RESPIRATORY FAILURE			
4.	ed sit	line	Sequentially list echolitions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			
>	xecut and	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of):			
2 R	le be executed ysicien and e burial-transit	calE	4			
5	ifficate g phy as the		U			
() ×	h cert endin	N/ug	IF FEMALE: 23b. Was decedent pregnant  23c. If yes, outcome of pregnancy  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of de	
Ε.	e deal he ett	sicis	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify)		Month	Day Year
9	hat the	Phy	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e Oid 1	tobacco use contribute t	o the cause of death?
Musion of Vital Records. P.O. Box	tending hysician: The law requires that the death certificate be executed bach.  Jeath.  tor: After this certificate has been signed by the ettending physicien and the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Med				robably 4 Unknown
CURRY Becords	aw red s bee 2 shoi	plete		24a. Was	an 24b. Were a	utopsy findings available
3 8	ician: The lav certificate has rector, page 2	mo		auto perfo 1 ☐ Yes	ormed? death?	completion of cause of
)     	ian: artifica ctor, J	Bec	25. Was case referred to medical examiner?	ath Check only	The state of the s	
785	hysic this ce al dire	2	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing H		idence 6 Other (Spe	ecify)
*UGUSEA	ding After	Certification	27. Manner of Death  1  Natural 5 Pending (Month, Day Year)  2  Natural investigation   Pending (Month, Day Year)   Sec. Injury at Work?	28d. Describe	how injury occurred	
1	death ctor: y the	licat	3 Suicide 6 Could not be	28f. Location (	Street and Number or F	lural Route Number.
Š	afte a afte d in	ert	4 Homicide determined determined building, etc. (Specify)	City or To	wn, State)	
	To the Hospital or "ttending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate has completely filled in Ly the funeral director, page 2	Medical C	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place (Check only one)	e, and due to the urred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Mec	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mon	th, Day, Year)
	F 3 ⊢ 8		D0069118		11-1-10	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	: 1	1 /	4.4
4 =			KhALID PUTHAWALA, MD 5015 UNIOWAVE	HAUre	GRACE GRACE	MD21078
10	Sta Registi		31. Date filed (Month, Day, Year)  32. Registrar's Signature  NOV 0 3 2010  33. Date filed (Month, Day, Year)			

**Physician** /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Division of Vital Records, P.O. Box 68760,

physician and the burial-trans the attending physician completely filled in by the

Physician

**Examiner** 

**Funeral** 

Director

28a-f show

Director

Funeral

2

Be Completed

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Examine

Physician/Medical

Be Completed by

Certification: To

Medical

item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the five discrete art is ust be inclined in

and Mental Hygiene.

es 1 and 2 should be fill of Health and Mental Fitem 27 is marked other

permit. Peges Department of Important; If its any Injury or o

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

/Medical

10a. State

MD

Cause (Disease or injury that initiated events	c	
resulting in death) Last	Due to (or as a consequence of):	
	d	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1  Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	23d. Date of delivery Month Day Year
Part II. Other significant conditions c	contributing to death but not resulting in the underlying cause given in Part I. 23e. Did to	obacco use contribute to the cause of death?
Atherosclerotic (	Cardiovascular Disease 104	es 2 No 3 Probably 4 Unknown
	24a. Was autop perlor 1 □ Yes	prior to completion of cause of death?
25. Was case referred to medical	26. Place of Death (Check only or	ne)
examiner? 1 ☐ Yes 2 ☐ <b>K</b> o	Hospital: 1   Inpatient 2   FR/Outpatient 3   DOA   Other: 4   Nursing Home 5   Resid	dence 6 ☐ Other (Specify)
27. Manner of Death ANatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)  28b. Time of linjury at Work?  M 1 Yes 2 No	now injury occurred
3 Suicide 6 Could not be 4 Homicide determined		Street and Number or Rural Route Number, vn, State)
29a. Certifier (Check only one)  Certifying Ph	nysician: To the best of my knowledge, death occurred at the time, date and place, and due to the miner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, and manner stated.	cause(s) and manner as stated. date and place, and due to the cause(s)
29b. Signature and title of certifier	A. ii	29d. Date signed (Month, Day, Year)
1	Attending Physician D51853	NAVEM5011, 2010
30. Name and address of person who	completed cause of death (Item 23a) (Type, Print)	,
Michael 5-1	completed cause of death (Item 23a) (Type, Print)  Noting 3001 501th Handwar Street	B=17-00-8 21225

State Registrar

31. Date filed (Month, Day, Year) 0 3 2010



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	State of Maryland /	Department of H	ealth and Mer	ntal Hygiene

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Hygiene	2	U	-	0	3	13	2	2	3

		1- For State Registrar		Cer	tificate c				icai i iy		eg. No.	20	1 0	3422
Physicia	n/	Decedent's Name (First, Middle,Las	•							. Date of Dea	th		,	3. Time of Death
ledical Examin	er	Jonathan Ro  4a. Facility Name (if not institution, giv		aytor	1 -	4h City	Tourn	r Location o		Month October 2		. County o	of Dooth	1235 hrs
		324 Highland Drive #T1	street and number)				Burni		or Death		- 1	Anne Ar		
Funeral		Social Security Number 6. S	x 7. Age	(In yrs. la	st birthday)	If Und	ler 1 Yea	ar If Unde	er 24Hrs.	8. Date of Bi	th(MM	/DD/YYYY		nplace (State or
Director			M 2 F		55 Yr		ns Day	ys Hours	Min.	June 2	1,	1955	Foreigi Cou	ntry) DE
y a		Usual Residence of Decedent  10a. State 10b. County		10c. City, 1	Town or Loca	ition								10d. Inside City Limits
daryland 28a-f show any 1 at once.	۱,	MD Anne A	rundel	(	Glen B	urnie	!							1 Yes 2 No
Maryla 28a-f	Director	10e. Street and Number				10f. Zip				1	0g. Citi	zen of Wh	at Coun	try?
h the ?		324 Highland Dri	ve #Tl				210	061				Į	J.S.	Α.
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	nera	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Armed Forces?					spanic Orig n, <b>Me</b> xican,		cify Yes or No ican, etc.)	-	14. Race White		an Indian, Black,
ifter de	긼	3 Widowed 4 Divorced		X No	1	Yes 2	No.	specify:				Specify:	Wh	ite
hours a	ed b	15. Decedent's Education (Specify or	ly highest grade com		16a. Decede			ition (Give I			16b. h	Kind of Bus	siness/In	dustry
36 in 72 l	Completed	Elementary/Secondary (0-12)	College (1-4 or 5	+)					add roth ot	-,				_
d with	탉	17. Father's Name (First, Middle, Last)	2			<u> Fechn</u>	11012		's Name (F	irst, Middle, I	Maiden		emi	cal
be filed within 7 be filed within 7 brital Hygiene. rked other than vent, the Medica	8	Orlo H. D.	ayton					Jes	ssie	V.		Gruwe	11	
D 21 should ind Mei is mai	-1	19a. Informant's Name/Relationship (T			41					al Route Nun				
mand 2 sho and 2 sho cealth and tem 27 is traumati		Mr. Stephen Dayto: 20a. Method of Disposition	n / Brothe		836 ace of Dispo				le [	Miller Date	SV1	lle,	MD City or T	21108 Town, State
Baltimore, permit. Pages I ar Department of He Important: If ite injury or other tr		1 XBurial 2 Cremation 3	Removal from Sta	cr	ematory or o	ther place)	)	- 1	Nov.	2,				
altin mit. P. partme portan	1	4 Donation 5 Other Specify: 21 Signature of Funeral Service Licens	see	Mead	lowrid;	ge Me Name and	M. I	s of Facility	1 2 2 2	2010	I E	IKT10	ige,	MD Burnie, MD
E P P E	1	Siline Sui	LMOIL		-					O L O III C				es, PA
Physician		23a. Part I. Enter the disease, or complete failure. List only one cause on ea	ch line.											Approximate Interval Between Onset and
Examiner	ĺ		Hypertens  Oue to (or as a conse			scler	oti	c car	diova	ascula	c di	lseas	e	Death
		Sequentially list conditions, b.	740 to (er 40 4 00/100	140/100 017										
	Ē	if any leading to immediate cause. Enter Underlying Cause	las to (or as a nonsa	quenee of;										
g- = =	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of)	:									
execute ian and al-tram		d.  X UNPENDED	MENDED											
760, icate be ephysicial	Medical	IF FEMALE:	AMENDED 23a, 27			E g90	9 1	1/5/1	0 TT		1 224	I. Date of o	Inliner	
687(errifica		3b. Was decedent pregnant in the past 12 months?	1 Live birth		2 F	etal death	3	Ectopic	pregnanc	у		Month	Da	y Year
Box 687 e death certific the attending ged for use as ti	/sician/	1 Yes 2 No 9 Unknown	4 Pregnant at t	me of dea	th 5 0	ther (Spec	cify)							
O. Bo at the de 1 by the tached f	چ١	Part II. Other significant conditions	contributing to death	but not res	ulting in the	underlying	cause (	given in Par	rt I.	23e. Did to	bacco ı	use contrib	ute to th	e cause of death?
ires that 1 signed b	o o	Diabetes melli	tus	_						1 Yes	2	No 3	Proba	bly 4 🗸 Unknown
w requisites the second should	Completed	_								24a. Was a autop:	sy			psy findings available mpletion of cause of
Recorder The la	é									perfor			eath? ✔ Yes	2 No
tal Recian: The certificate ector, page	ag.	25. Was case referred to medical examiner?	ospital: 1 Inpatien	_				of Death (						
Physi Prysi er this	۱2	1 Yes 2 No	28a. Date of Injury		R/Outpatient 28b. Time of			ry at Work?		dome 5				Scene
Division of Vital Records, tal or Attending Physician: The law require is after death.  al Director: After this certificate has been signed in by the funeral director, page 2 should be in the funeral director, page 2 should be in the funeral director, page 2 should be in the funeral director, page 2 should be in the funeral director, page 2 should be in the funeral director, page 2 should be in the funeral director, page 2 should be in the funeral director, page 2 should be in the funeral director, page 2 should be in the funeral director, page 2 should be in the funeral director.	Certification:	1 X Natural 5 Pending	(Month, Day,Ye	ar)	-50: 11110 01	,		res 2		d. Boodingo ii	iow inju	., 0000.10	•	
ViSi or Atte fler de Directo in by t	E	2 Accident Investigation 3 Suicide 6 Could not be	28e Place of Inju	ry - At hon	ne, farm, stre	et, factory,	office b	uilding, etc	28			nd Number	or Rura	Route Number, City
Divis Divis 24 hours after d Funeral Direc tely filled in by		4 Homicide determined	(Specify)							or Town, St	(ate)			
	<u></u>	29a. Certifier 1 Certifying Physicia (Check only) 2 Medical Examiner:	n: To the best of my On the basis of exam											
To the within 2 To the complete	Med	29b Signature and title of certifier	and manner stated.					e number						h, Day, Year)
,		U-m)-					O.C.I	M.E.			Octo	ber 28,	2010	
1 Sign	+	30. Name and address of person who co	ompleted cause of de	ath (Item 2										
oxperd			Assistant Medica			Penn S	Street,	Baltimo	re, MD	21201				
Star Registra		31. Date filed (Month, Day, Year)	32 Registrar's	Signatur	. /	thad								

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. C Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Physician/ 44+ M iam 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BOYNIEW MED If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Dec. 26 Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days 1 ፟፟፟ M 2 ☐ F Months Hours Country) **Director** 032-26-8431 1933 Massachusetts Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rector 1 Yes 2 X No Maryland Wicomico Salisbury ā 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21804 902 West Schumaker Manor Drive USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ★ Yes 2 □ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: 3 Widowed 4 Divorced White traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed withir Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic event, the 1 once. Clothing Retail Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Clara Elizabeth Holmes George Vincent Carrolan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clarisse L. Dunham / Wife 902 West Schumaker Manor Drive, Salisbury, MD 21804 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hilltop Service Corp 11-1-10 Towson, Maryland <sup>22</sup> Name and Address of Facility 1 Home, P.A. MCComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 Signature of Fune al Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Lespirator disease or condition resulting in death) Medical **Examiner** nellmenia Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) the burial-transit Cause (Disease or iiniury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical 68760 38 IF FEMALE: asn Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No After this certificate has been signed by the atte funeral director, page 2 should be detached for Day Pregnant at time of death 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 hknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? or Attending Physician: The 2 🗌 No Yes 2 LINC 1 Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital: မ 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 1 Natural 5 Pending 2 🗆 No Investigation ☐ Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) 765-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Lastern RUIN Soares 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 5:55 PM Sinsat Duffy 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death R osedale Square Baltimore lin Social Security Number If Under 1 Year If Under g. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🛣 F (Month, Day, Year) 03/19/1932 Months Davs Hours Country) Director 78 438-44-7988 Louisiana Usual Residence of Decedent permit. Page 1 and 2 should re filed withir 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is married other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City. Town or Location Director 10d, Inside City Limits 1 🗌 Yes 2 🔀 No Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 910 Homberg Avenue 21221 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 🛛 No Specify. Specify: 3 Widowed 4 X Divorced Completed Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sinsat Maria Niche 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Duffy / Son 15 Juliet Lane, Unit 102, Baltimore, MD 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State Anatomy Gifts Registry 11/01/2010 | Hanover, Maryland 4 Donation 5 Other (Specify) 21. Signature of Fureral Service Censes 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, of complications that caused shock, or heart failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) therosclerotic Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the bunal-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death ed by the detached Unknown signed if Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed been si 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? Yes 2 No death? eral Director: After this certificate if filled in by the funeral director, page 1 Yes 2 No ☐ Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 I DOA 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 🗹 Natural 5  $\square$  Pending ☐ Accident ☐ Suicide Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. City or Town, State) within 24 hours a

To the Funeral Completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day. Year) 0 D 3559 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

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arke

Franklin

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Oct obe Year Physician/ 8: 22 PM Jordon 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore University of Maryland Medical Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | Min. | May 18, 1937 5. Social Security Number 217-34-3165 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1**2**□ M 2 □ F 73 **Director** MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show ampigury or other traumatic event, the Medical Examiner must be notified to once. 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location Director Aberdeen Harford MD 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 21001 W. Aztec Street 10 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: White 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Food Manufacture Elementary/Seconday (0-12) College (1-4 or 5+) Laborer 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Donaldson unkh. ည 19a. Informant's Name/Relationship (Type, Print)
Wayne Donaldson / Son 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zin Code) 1339 Pontiac Avenue, Baltimore, MD 21225 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State rinal Journey Crem. 1 Burial 2 X Cremation 3 Removal from State 11/03/2010 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final pticemia Ph sician/ 2 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Oliti Sequentially list conditions, if any, leading to immediate Examiner attending physician and for use as the burial-transit Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy been signed by the atte should be detached for in the past 12 months? Day 5 Other (specify) Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Coronory 2° No 3 ☐ Probably 4 ☐ Unknown Artery 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 2 s 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: P 2 No 1 🗌 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 24 hours after death. Funeral Director: After this 28a. Date of injury (Month, Day, Year) filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 2 Accident
3 Suici injury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29 c, License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South Greene Street Bultmore, MOZIZOI Hunter Bogg 32. Registra's Signature 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2DIC Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death **Examiner** 4b. City, MALKO 8. Date of Birth (Month, Day, Yo 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Min. Months Hours Director MD Usual Residence of Decedent or 28a-f shov 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Yes 2 ☐ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2121 S.A death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examin þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Completed 3 Divorced Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Retail Stocker 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eleanor Clinton William Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annette Clark 2528 Loyola Southway, Baltimore Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of matory or other place cemetery, cri 1 Burial 2 Cremation 3 Removal from State Cremator Catarsville 4 Donation 5 Other (Specify) 21. Signat of Fun ru Service Licenses 22. Name and Ad ess of Facility 7221 Grayburn Burnie, F .S Glen Harman 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between nel nset and Death Immediate Cause (Final 8 leu Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Due to for as a consequence of if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examin burial-tran Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 Yes 2 No 3 Probably 4 Unknown cate has been signated; page 2 should b Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy certificate 2 🗆 No Yes 2 1 No 1 Yes Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 1 No ဂ္ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury Natural 5  $\square$  Pending 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29b. Signature and title of certifie 29d. Date signed (Month. Day. Year) 2010 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) FALTIMONE MU 21209 2835 CHERUCET AVE SUITE 203 STUTH W. 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 27, 2010 7:45 Charles Diss Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Rockville Montgomery National Lutheran Home Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** 1 🛛 M 2 🗆 F Months Days Min. (Month, Day, Year) December 16,1929 522-34-9327 80 Director Colorado Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10326 Lloyd Road 20854 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give TATA Black, White, etc. δ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates. WW II Specify: White Completed 3 Widowed 4 Divorced other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Engineer IBM- Computers Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ William T. Diss Eleanor Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sylvia Diss/ Wife 10326 Lloyd Road Potomac, Maryland 20854 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot October 30, emetery, crematory or other place) 1 🗆 Burial 2 🖾 Cremation 3 🗀 Removal from State Montgomery 2010 4 Donation 5 Other (Specify) Bethesda, Maryland rematoriúm 22. Name and Address of Facility Robert A. Pumphrey Funeral Home—Rockville, Inc. 21. Signature of Funeral Service Lic M01607 Montgomery Avenue Rockville, Maryland 300 W. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode, f dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause in each li-Immediate Cause (Final One t and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events sumon attending physician and for use as the burial-trans resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Pregnant at time of death 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 100 ပ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending Accident
Suicide 1 Yes 2 No Investigation 24 hours after deatle Funeral Director. 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, determined Ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature 29c License number

State Registrar

10+1

31. Date filed (Month, Day,

30. Name and address of person who completed cause &f death (Item 23a) (Type, Print)
Charles W. Karesh, M.D. 26033 Ridge Road, Damascus, Maryland 20872

			_	Type or Print in E State of Marylan						_	
		-	For State Registrar		C	Certificate of	Death		Reg. No	2010	34229
			1. Decedent's Name (First, Middle, Last	)				2. Date of D Month	Da	y Year	3. Time of Death
	Physicia /Medic	_	Doris	Mae	De1	ker		Octobe			4:50 p <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give	street and number)			or Location of Deat	h		. County of Deat	th
			Future Care  5. Social Security Number 6. Se	x 7. Age (In yrs.	last hirthi	Baltime		8. Date of E	Birth	V/A 9. Biri	thplace (State or Foreign
	Funeral Director			_м 2 <b>К</b> Г	Yr	Months Day		Dec. 9	Day, Year,	28 Mai	ryland
		ŀ	Usual Residence of Decedent								1011 11 02 11 02
	show	_	10a. State 10b. County	_		or Location					10d. Inside City Limits 1 ☐ Yes 2√√√No
	Ba-f s	Director	MD Anne Aru	ndel Pas	sadeı				100 0	itizen of What Co	
	with the	늅	10e. Street and Number	D. I		10f. Zip Code			USA		January.
	eath '	Funeral	1637 Grandview	12. Was Decedent Ever in U.	S.	21122 13. Was Decedent of If Yes, specify Co		Specify Yes or I		14. Race - Ame	
0	fter d riten viner	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No				to Rican, etc.)		Black, Whit	
03	ours a ral",o Evan	i by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 □Yes 2 🔀 N	o Specify:				White
2-0	72 hc 'natur	etec	15. Decedent's Edu (Specify only highest grad		) (	Decedent's Usual Occ Give kind of work dor	e during most of wo	rking	16b. l	Kind of Business	/Industry
121	vithin ene. <b>than</b> '	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		ife. DO NOT use reti nemaker	rea)		Ow	n Home	
0 0	filed within 72 hours after death with the Maryland Hygiene. Hydiene. The Williams 23a or 28a-f show ther than "natural", or items 23a or 28a-f show ant, the Modicel Examiner must be notified at	ပိ	17. Father's Name (First, Middle, Last)		1101	пешакет	18. Mother's Na	me (First, Mida			
an	ould be f Mental arked o atic eve	To Be	Francis	Lages	5		Lilli	an		W	right
ary	g E E	-	19a. Informant's Name/Relationship (7	ype. Print)	19b. l	Mailing Address (Stre	et and Number or F	ural Route Nur	nber, City	or Town, State,	Zip Code)
Baltimore, Maryland 21215-0036	and 2 salth a n 27 is		Kathy Sanders (Da			7 223rd St					
ore	les 1		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐	Removal from State	Place of E emetery,	Disposition (Name of crematory or other p	lace)	Date /10		ocation - City or	
Ē	t. Pages tment of tant: If ite		4 ☐ Donation 5 ☐ Other (Specify	) LOI	uaon	Park Ceme					Maryland
Ba	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra		21. Signature of Funeral Service Licens	see			dress of Facility I .1kens Ave				
22			23a, Part I tomer the disease, or comp	olications that caused the deat	h. Do no		_			C, 11D Z.	Approximate
	Neurisian		lmmediate Cause (Final	one cause on each line.		ANEURY					Interval Between Onset and Death
4	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a conseq			8,-1				
1	Examiner		<b>i</b>	b- DEm	ENT	1 A					
	# # C	ner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseq							
	e executed an and rial-transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conseq							
60,			iodaming in addition		uerice or	<i>j.</i>					
6876	eath certificate be attending physici for use as the bu	Physician/Medica		d						1.77	
XC	nding nding use a	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn		2 T 5				23d. Date of de	
P.O. Box	death e atte d for	icia	in the past 12 months? 1 □ Yes 2 ☑ No	1 Live birth 2 Feta 4 Pregnant at time of		3 ☐ Ectopic pregnation 5 ☐ Other (specify			-	Month	Day Year
<u>Ч</u> О	that the de ned by the a detached t	hys	9 ☐ Unknown				otions to Death	220 D	id tobacc	uea contribute	to the cause of death?
ś	w requires that s been signed I should be det	þ	Part II. Other significant conditions of	ontributing to death but not res		tne underlying cause	given in Part I.				Probably 4 Unknown
ord	requii	eted	DAGE TE	11000							
3ec	e law has b je 2 sl	Completed						24a. W - au	ras an utopsy erformed?	prior to	autopsy findings available completion of cause of
a	i <b>ician:</b> The certificate ector, pag		OF War and to make an alice!		_		26. Place of D	1 ☐ Ye		√o 1 □Ye	es 2 No
<u> </u>	sicial certi irecto	Be C	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐	1 FB/Out	nationt 3 DOA	Othor			6 ☐ Other (Sp	necify)
o	g Physer this eral dir	Ë	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Ti	me of 28c. I	njury at Vork?			jury occurred	
<u>.</u>	ath. r: After	atio	1.☐Natural 5 ☐ Pending 2 ☐ Accident investigation				□Yes 2□No				
Division of Vital Records,	r Atte ter de irecto	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Spec	ome, fari	m, street, factory, offi	ce	28f. Locatio City or	n <i>(Str</i> eet To <i>wn, St</i> a	and Number or I ate)	Rural Route Number,
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page			1		-111	- 11 data and ala	and due to	the source	(c) and manner	as stated
	Hospita 24 hours Funeral	Medical	29a. Certifier  (Check only 2 Medical Examone)	ysician: To the best of my kn niner: On the basis of examin and manner stated.	owledge, ation and	death occurred at the discourred at the discourr	ny opinion, death oc	curred at the tir	ne, date a	and place, and d	ue to the cause(s)
	To the I within 2 To the I compler	Mec	29b. Signature and title of certifier	and mariner stated.		29c. Lic	ense number		29d. [	Date signed (Mo	nth, Day, Year)
	⊢ ≯ F ŏ		1	ATTEMONY		Do	056948	?	~	W /	2010
			30. Name and address of person who	completed cause of death (Ite	m 23a) (				-		2,220
_			JAMES TANSIN			NO AVE	Suit 2	04 /31	Tum	we w	) ( ( 4
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	1.1					
	riegist	4.1	BUILD IS "7 7 [11]	6 12 care A 1 PT A	613 155 R. P.	CENT .					

DHMH 17 Rev 1/2001

			For State	State of	Maryland		artment of l rtificate of		and Mei	ntal Hy	giene Reg. No	2010	34230		
			Registrar  1. Decedent's Name (First, Mid	Idle, Last)			timodic or	Dodin	2.	Date of De	ath		3. Time of Death		
	Physicia /Medic		VELLA	W. ELL	ENBERGER				04	Month Stober	. 30				
Town or the	Examin		4a. Facility Name (If not institut	-			4b. City, Town,					County of Death			
Tarak .			BAHMORE WASL 5. Social Security Number		. Age (In yrs. la		Gkn If Under 1 Year			Date of Bir		UNE Ara	place (State or Foreign		
	Funeral Director		216-20-1401	1 M 2 M F	83	Yrs.	Months Days	Hours	Min. J	Date of Bir (Month, Da uly 6	, Year) , 192	Cou	vland		
	D		Usual Residence of Decedent  10a. State 10b. Cour	the state of the s	10c City	, Town or Lo	cation						10d. Inside City Limits		
	f show	o			Too. Oily		Burnie						1 ☐ Yes 2 🗷 No		
	r 28a-	irect	Maryland Anne  10e. Street and Number	Arundel		GIEI	10f. Zip Code				10g. Cit	izen of What Cou	ntry?		
	h with 23a o	al D	2700 Finch Road	l			21	060			U	.S.A.			
	ems ems	ner	11. Marital Status	12. Was Deced Armed Ford	ent Ever in U.S	3. 13.	Nas Decedent of f Yes, specify Cub	Hispanic Ori oan, Mexicar	igin? (Specif	y Yes or No an, etc.)	0-	14. Race - Amer Black, White,			
36	hours after death with the Maryland tural", or items 23a or 28a-f show in Ever it with the multised at	y Fi	1 ☐ Never Married 2 ☐ M 3 ☐ Widowed 4 🛣 Divorc	I If Yes Give	9		1 □Yes 2X No	Specify:				Specify: Whit	e		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exp. it at the continued any injury or other traumatic event, the Medical Exp. it at the continued and once.	Completed by Funeral Director	15. Deced	ent's Education			dent's Usual Occu		at and consistence		16b. K	ind of Business/I	ndustry		
215	thin 7. ne. nan "n	nple	Elementary/Secondary (0-12		for 5+)	ilfe. I	kind of work done DO NOT use retire	ed)			D <sub>o</sub> 1	land Brotl	howa		
121	led wi tygier her th		11 17. Father's Name (First, Midd.	(o ( oct)		Nationa	al Credit A		Managei er's Name <i>(F</i>				lers		
anc	d be fi	o Be	Arthur Patrio						rude Agr		Shughr				
aryl	shoul and Ma mari umatl	P L	19a. Informant's Name/Relation			19b. Mailir	ng Address (Stree						ip Code)		
ž	and 2 ealth a n 27 ls		Joanne H. Virts	(Daughter)			Finch Road	·							
ore	t of He		20a. Method of Disposition 1    Burial 2 □ Crematio	n 3 🗆 Removal from Si	20b. Pi	ace of Dispo emetery, crer	sition (Name of natory or other pla		Date			ocation - City or T			
Baltimore,	it. Pag rtmen rtant: njury		4 ☐ Donation 5 ☐ Other	(Specify)		1	Mem. Park 2. Name and Addr		A			Burnie, M			
Ba	Departing Department of the partment of the pa		21. Signature of Funeral Servi	1 TOW	ull	/			MCCUL			Funeral H nd 21122	ome P.A.		
			3204 Mountain Road, Pasadena, Maryland 21122 23a. Port. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death												
1	Physician		mediate Cause (Final sease or condition	nonediate Cause (Final sease or condition esulting in death)  a. Hemorphasic Strake  Due to (or as a consequence of):											
4	/Medical Examiner		Due to (or as a consequence or):												
		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (o	r as a consequ	ience of):									
013	acuted nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undergring Cause (Disease or injury that initiated events	с											
8760,	cate be executed physician and the burial-transit	E	resulting in death) Last	Due to (o	r as a consequ	ience of):									
687	ficate physi s the t	edical		d											
Box (	eath certific attending p	J/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc			75.4					23d. Date of deli	very		
. B	requires that the death certificen signed by the attending thould be detached for use as	Physician/Me	in the past 12 months? 1 □ Yes 2 ☑No		rth 2□Fetal ant at time of d wn		☐ Ectopic pregnar ☐ Other (specify)	icy				Month	Day Year		
P.0	w requires that the de been signed by the should be detached	Phy	9 Unknown  Part II. Other significant cond			ulting in the U	nderlying cause g	iven in Part I	l.	23e. Did	tobacco	use contribute to	the cause of death?		
Vital Records,	uires t signe Id be c	Completed by	and of our				, , , , , , , , , , , , , , , ,			1 🗆	Yes 2	No 3□ Pro	obably 4 🗌 Unknown		
000	faw req as beer 2 shou	lete								24a. Wa		24b. Were au	topsy findings available		
R	sician: The law certificate has b irector, page 2 sl	mo:								auto perl 1 □Yes	opsy formed? 2 <b>2</b> 40	death?	ompletion of cause of 2 🗖 No		
/ita	ysician: is certifica director, p	BeC	25. Was case referred to medi examiner?						e of Death						
of \	Physician: this certific		1 Yes 2 No		patient 2	ER/Outpatie	IL 3 LI DOA					6 ☐ Other (Spec	cify)		
on	ding I h. After funer	tion	27. Manner of Death 1 ☑ Natural 5 ☐ Pen 2 ☐ Accident inve	ding 28a. Date o (Month estigation	n, Day, Year)	Injury	We	urya≀ ork? ∐Yes 2. □		a. Describe	now inju	iry occurred			
Division of	Atten	ifica	3 Suicide 6 □Cou	lid not be 28e. Place of	of Injury - At ho g, etc. (Specify	me, farm, str	eet, factory, office		281	f. Location	(Street a	nd Number or Ru	ral Route Number,		
Ö	ital or irs afte ral Dir iled in	Cert													
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral directal	Medical Certification: To	29a. Certifier 1 Certification (Check only one)	fying Physician: To the local Examiner: On the ba and mann	sis of examina	tion and/or in	nvestigation, in my	opinion, de	ath occurred	at the time	e, date an	nd place, and due	s stated. to the cause(s)		
	Vithin To th	Me	29b. Signature and title of cert	ifier			29c. Licer	nse number			29d. Da	ate signed (Monti	n, Day, Year)		
			Hey In	and my	>		Pos	2741	5		Oct	ben 30,	2010		
	6		30. Name and address of pers	on who completed cause	of death (Item	23a) (Type,	Print)	to N	1-1:	1 (	اسلا	<u>-</u>			
	Sta	ite	31. Date filed (Month, Day, Ye	ar) 32. Re	egistrar's Signa	ture	MINDA(N)	, ,	-رين	, ,,	~~		<u> </u>		
	Registi	ar	NOV 0 3 201	1 Densin	1. 19	arked	Print) Washing			<u></u>					

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Augusta Famey		1- For State Registrar	State	e of Marylar		rtment of H tificate of D		ental Hyglene	2010 Reg. No.	34231			
Physicia Medical Examir		Decedent's Name	•	,				2. Date of De	eath Day Year	3. Time of Death 1538 hrs			
Medical Exami	ier	Augusta 4a. Facility Name (if	t f not institution, g	The	resa		Fairley City, Town, or Locatio		28, 2010 4c. County of De				
		2400 Molton					/indsor Mill		Baltimore C	ounty			
Funeral Director		5. Social Security N			. Age (In yrs. la		Under 1 Year If Ur	urs Min	Birth (MM/DD/YYYY) 9. For	eign			
Director		212-56-2 Usual Residence of	-1	M 2_ <b>_</b> XF	57	Yrs.		08	03 53	Country) MD			
any			10b. County		10c. City, 1	Town or Location		-		10d. Inside City Limits			
and show	ō	MD				Wind	dsor Mil.	1		1 X Yes 2 No			
Maryl r 28a-l	Director	10e. Street and Nun	nber	<u></u>		10	f. Zip Code		10g. Citizen of What Co	ountry?			
ith the \$ 23a o		2400 Mo	olton W		dent Ever in U.S	13 Was De	2124	4 Origin? (Specify Yes or N	U.S.A	erican Indian, Black,			
leath v	Funeral	1 Never Mame	ed 2 K Marrie					an, Puerto Rican, etc.)	White, etc				
after c	by F	3 Widowed		ed If Yes, Give Year or Dates:		1 Yes			Specify: B				
2 hours	eted	15. Decedent's Ed Elementary/Seco		only highest grade College (1-4			sual Occupation (Giv of working life. DO NO		16b. Kind of Busines Persona				
036 thin 73 ne.	_	12th gra	* ' '	lyr	(3.0.)	Cosmeto	ologist		Hair Sa				
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica		17. Father's Name (	First, Middle, Las					er's Name (First, Middle	-	- 1			
2121 ald be i Mental marke	_ 1	James Pi 19a. Informant's Nar		(Type, Print )		19b. Mailing Add	Luc:	ille Pinke	ett ımber City or Town, Sta	ite, Zip Code) 21117			
	- 1	Kellie P	·		er	5136 V	Jagon She	ed Circle	Owings	21117 Mills, Md			
Baltimore, MD permit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumati		20a. Method of Disp	osition	17%	20b. Pl	lace of Disposition ematory or other p	(Name of cemetery,	Date	20c. Location - City	or Town, State			
imo Page ment c		1 Burial 2 Donation 5	X Other Specif	oleum Cryp	Kin			11/6/201	d Woodlaw	n, Md			
Ball permit Depart Impor		21. Sgnature of Fun	neral Service Lice	ensee K	k.	IMarc	and Address of Faci	est		3 21215			
Physician	March F/H West 4300 Wabash Ave, Baltimore, Md  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
Examiner		Immediate Cause (F	inal disease	Atheros			vascular	disease		Between Onset and Death			
	Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic cardiovascular disease Due to (or as e consequence of):  b.												
	Je.	if any, leading to im- cause. Enter Under	mediate	Due to (or as a co	onsequence of):	:				Ţ.			
.=	Examiner	(Disease or injury the events resulting in dis	at initiated	Due to (or as a co	onsequence of):								
ox 68760, anh certificate be executed attending physician and or use as the burial - transit	ä	<b>\\ 77</b> \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\		d. X AMENDED #2	Oa.perH	н,с910,12/	8/10.WS						
te be exysician	ভ	X UNPENDED		23	a,2/,pe	er ME g91	0 12/7/10	TT	23d. Date of delive				
5876 ertificat ling ph	an/N	23b. Was decedent p past 12 months?		1 Live birt		2 Fetal de	eath 3 Ector	pic pregnancy	Month	Day Year			
Sox Jeath c e atten for us	Physician/	1 Yes 2 N	o 9 🗸 Unknov		it at time of deat n	th 5 Other	(Specify)		X 10.				
		Part II. Other signifi	icant conditions	contributing to d	eath but not res	sulting in the under	lying cause given in I		tobacco use contribute	_			
S, P, uires th uires the n signe Id be de	ed by								es 2 No 3 Pr				
ord law req has bee	Completed							24a. Was		autopsy findings available completion of cause of			
tal Records, cian: The law requirecertificate has been rector, page 2 should		05 W	T				20 51 (5	1 Yes		Yes 2 No			
Vital Vsician vsician directo	ω̈́,	25. Was case referre examiner?  1  Yes 2		Hospital: 1 Inp	atient 2 E	R/Outpatient 3	- IOthan 5	h (Check only one)  Nursing Home 5	Residence 6 🗸 Oth	er: Scene			
ing Phy After the	일	27. Manner of Death		28a. Date of (Month, D	Injury 2 ay,Year)	28b. Time of Injury	28c. Injury at Wo	rk? 28d. Describe	how injury occurred				
Sion Attendideath.	[gtio	Natural  Accident	5 Pending Investiga	ition			1 Yes 2						
Divisi pital or At ours after d neral Direct filled in by	Certification:	3 Suicide 4 Homicide	6 Could no determin	t be	of Injury - At hom	ne, farm, street, fac	ctory, office building,	etc. 28f. Location or Town,		Rural Route Number, City			
Divisio  To the Hospital or Attenwithin 24 hours after deat To the Funeral Director		29a Certifier	Certifying Physic	cian: To the best of	f my knowledge	e, death occurred a	t the time, date and p	place, and due to the cau	se(s) and manner as st	ated.			
To the Hos within 24 h To the Fur completely	Medical	- (-)		er:On the basis of e and manner stat		d/or investigation, i		occurred at the time, date					
	≥	29b. Signature and to	itie of certifier	11/ 00			O.C.M.E.	er	29d. Date signed (M October 30, 20				
4	-	30. Name and addre	ss of person who	completed cause	of death (Item 2	(3a)	U. U. 171. L.,		] 55,555, 50, 20				
or be.		Margarita Ko	rell MD. A	ssistant Medic	al Examine	r 111 Penn	Street, Baltimor	e, MD 21201					
Sta Registr	ite ar	31. Date filed (Month	3'2010	32. Regis	strar's gnature	parke							
		110											

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			State of Ma	aryland / Depa			nd Mental Hy	giene	21222
			Registrar	Cer	rtificate of L	<i>Jeath</i>		Reg. No. U U	34232
	Physicia		1. Decedent's Name (First, Middle, Last)  Henry Marshall Fales III				2. Date of De Month	ath Day Year 28/2010	3. Time of Death 1:30 A M
4	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of D		4c. County of Dea	ath
-,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	!		3114 Gracefield Rd.		Silver	Spring		Montgome	ry
	Funeral Director		5. Social Security Number 124–22–4090	(In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of Bir Vin. (Month, Da 02/12/		rthplace (State or Foreign ountry)  New York
4.			Usual Residence of Decedent				02/12/	1921	New TOTA
	yland f sho ed at	ctor	10a. State 10b. County	10c. City, Town or Lo					10d. Inside City Limits
	e Mar r 28a notifi	Director	MD Montgomery  10e. Street and Number	Silver Sp	10f. Zip Code				1 Yes 2 No
	ith th	ral						10g. Citizen of What C	•
	ems r	Funeral	3114 Gracefield Rd.  11. Marital Status 12. Was Decedent E	ver in U.S. 13. \	20904 Was Decedent of H	ispanic Origin?	? (Specify Yes or No-	United Sta	
9	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantla Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	Armed Forces?  1 □ Never Married 2 ▼ Married 1 ▼ Yes 2 □ 1	No.	f Yes, specify Cuba	ın, Mexican, Pu	uerto Rican, etc.)	Black, Whi	te, etc.
Baltimore, Maryland 21215-0036	ours af tural" al Exa	Completed	Year or Dates.		1 Yes 2 No			Specify: W	
15-	72 ho n "na Nedic	nple	15. Decedent's Education (Specify only highest grade completed)	(Give i	dent's Usual Occup kind of work done o O NOT use retired)	ation during most of	working	16b. Kind of Business	s Industry
212	vithin giene. er tha		Elementary/Seconday (0-12) College (1-4 or 5	+) Chemi	,			Research	
nd	filed v al Hyg d othe	Be	17. Father's Name (First, Middle, Last)	· · · · ·		18. Mother's	Name (First, Middle,	Maiden Surname)	
yla	Ild be Ment narke natic	잍	Henry Marshall Fales Jr.				e Marie Va		
Mar	2 shouth and the and the and the and the and the and the and the ann t		19a. Informant's Name/Relationship (Type, Print)  Caroline E. Fales- Wife	<b>I</b>	-			r, City or Town, State, Z ring MD 20	
ē,	I and I Heal!		20a. Method of Disposition	20b. Place of Dispo	sition (Name of	!	Date	20c. Location - City of	
mo	age of the sent of		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 🕱 Donation 5 ☐ Other (Specify)	Uniformed Univers	natory or other place Service:	s _ 10	)/29/2010	Bethesda	MD
alti	permit. I Departm Importa any inju once.		01.01 1.75 10.1.11		2. Name and Addres				t Ave. 20910
<u> </u>	e a m e e	5 X	Stiplist Johnnam	Ra	pp Funera	al & Cr	remation S	er. Silver	Spring MD
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line		er the mode of dyin	g, such as card	diac or respiratory ar	rest,	Approximate Interval Between
F	hysician/ Medical	8 /3		tic Melan	oma			V.	Onset and Death
للهسب	Examiner		Due to (or as a	consequence of):					
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	consequence of):					
	cuted ind transit	Examiner	that initiated events c						
_	icate be executed g physician and is the burial-transit	dical E	resulting in death) Last Due to (or as a	consequence of):					
760	cate by physical phys	edic	d						
9	ath certifica attending p	M/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of	of pregnancy	7			23d, Date of d	elivery
Box 687	death ie atte ed for	Physician/Me	in the past 12 months?  1  Yes 2 No  1 Yes 2 No  1  Yes 2 No  1  Yes 2 No		☐ Ectopic pregnand ☐ Other (specify)	;y		Month	Day Year
P.O.	at the dea I by the a etached	Phy	g Unknown  Part II. Other significant conditions contributing to death by	it not resulting in the u	ınderivina cause aiv	ven in Part I	220 Did t	obacco use contribute t	o the cause of death?
٠ <u>,</u>	v requires that s been signed t should be det	Completed by	Tarkii. Othor significant conductors contributing to death of	at not roodining in the d	indenying eddee gri	on in rait i.			Probably 4 🖾 Unknown
ord	requi been shouk	lete					24a. Was	an 24b. Were a	utopsy findings available
ec	he law te has age 2 :	omp					— auto	osy prior to ormed? death?	completion of cause of
a F	Physician, The lav r this certificate has ral director, page 2	Be C	25. Was case referred to medical examiner?		26. Pl	ace of Death (0	Check only one)	2 No 1 □ Ye	35 2 LI NO
ξ	hysici nis ce I direc	일	Hospital:	nt 2 ER/Outpatier	nt 3 DOA Othe	er: 4 🗀 Nursir	ng Home 5 🔀 Resid	dence 6 D Other (Spe	cify)
Division of Vital Records,	ling P	ate:	27. Manner of Death  1 X Natural 5 Pending  28a. Date of injur (Month, Day,	y 28b. Time of injury	work	?		now injury occurred	
Sion	ul or Attending P s after death. I Director: After t d in by the funers	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injur	ry - At home, farm, stre		Yes 2 ☐ No		Street and Number or R	ural Route Number.
ΞŽ	pital or Atteno ours after death eral Director; filled in by the		4 Homicide determined building, etc.		, 100101), 011100		City or Tov		ara risate rianisei,
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	the F thin 24 the F mplet	Me	only one) 3 Certifying Nurse Practioner: To the b		death occurred at the	e time, date and		e cause(s) and manner a	s stated.
	5.≱ 6 8		Andrew Ruder	Simo	29c. License D0036			29d. Date signed (Mon 11/01/2010	
	0		30. Name and address of person who completed cause of de			110		11/01/2010	
11			Andrew Kundrat MD 3110 Grad		*	Spring	MD 20904		
	Stat		31. Date filed (Month, Day, Year) 32. Registra	's Signature					
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year 3,30 Physician/ Jewins Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Mm If Under 1 Year If Under 24 I 5. Social Security Number Birthplace (State or Foreign Country)
 MD Date of Birth 7. Age (In yrs. last birthday) **Funeral** Min. 1 X M 2 🗆 F Months Days Hours 0392771931 MD79 218-26-5265 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10a. State by Funeral Director 1 Yes 2 X No ELDERSBURG CARROLL MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21784 USA 2029 - 3D RUDY SERRA DRIVE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: WHITE Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) INSURANCE SALES Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ LURIE FRIED ROSE SAMUEL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2029-3D RUDY SERRA DRIVE, ELDERSBURG, MD ROSE FRIED/WIFE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 ▼Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) OHEB SHALOM MEM. PK. 11/01/2010 REISTERSTOWN, MD Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Mad 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ o for as a consequence of): min. Ti disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Dille to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Innerial director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) g Unknown g 🗌 Unknown P.0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ Ho 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 Tes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 2 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Certificate: injury 1-ANatural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , 32 Registrar's Schature State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician/ 7:00 A MOSES GUESS, SR. 10 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner **4802 BEAUFORT AVENUE** BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** Months Min. 1 X M 2 D F Hours Director 254-38-8471 03-15-1927 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director MD BALTIMORE 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ral", or items 23a or Examiner must be Completed by Funeral **4802 BEAUFORT AVENUE** USA 21215 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: BLACK 3 Widowed 4 Divorced Year or Dates the Medical 16a Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nd Mental Hygiene.
marked other than
matic event, the Mo Elementary/Seconday (0-12) College (1-4 or 5+) TRUCK DRIVER KAYDON RING AND SEAL permit. Page 1 and 2 should be filed a Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ **PURDIS VICTORIA** JOHN. GHESS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) WILLIAM GUESS 3116 PRESSTMAN ST., APT 1, BALTO., MD 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State CEDAR HILL CEM Donation 5 Cher (Specify) 11/06/2010 | BALTIMORE, MD 21. Signature of Funeral Service Licensee 22, Name and Address of Facility JAMES A. MORTON & SONS F.H. INC 1701 LAURENS ST. BALTO. MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final metastanc Physician/ Cancer UN KNOWN disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if dry, leading to in necial cause. Enter Underlying Examine Due to lor as a consequence of Cause (Disease or linjury the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Veal Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Yes 2 🗌 No 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? perform Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending work? 1 ☐ Yes 2 ☐ No Natural injury 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 2 20 IV address of person who completed cause of death (Item 23a) (Type, Print) HARVES 6701 N Charles ST CW 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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	1	State of Maryland / Dep State of Maryland / Dep Registrar  Ce	artment of F				giene	010	34235
Physician	١.	1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month	Day	7(a)	3. Time of Death
/Medical Examiner		4a. Facility Name (If not institution, give street and number)	4b. City, Town, o	or Location of	of Death		4c.	County of Dea	
	v	Bowiettealth Center	Bow	sie				rince	
<ul><li>Funeral Director</li></ul>		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Yrs.	Months Days		Min.	8. Date of Birtl (Month, Day	y, Year)	9. Bi	rthplace (State or Aoreign ountry)
land	-	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or L	ocation			' !			10d. Inside City Limits
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ath w		2812 Spiral Lane	20715			* * *	USA		-in- to the
5-0036 72 hours after death with the Maryland natural; or items 23a or 28a-1 show dical Examinar must be notitled at eted by Funeral Director		11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 XYes 2 No. 14 In Yes, Give Year or Dates: 1974	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 X No			erry Yes or No- Rican, etc.)		14. Race - Am Black, Wh Specify:	ite, etc.
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Baltimore, semit. Pages 1 au bepartant of Heamportant: If them in yinjury or other more.		20s Method of Disposition 20b Place of Dispo	osition (Name of matory or other pla	ice)	Da	ate	20c. Lo	cation - City o	r Town, State
altimo		4 Donation 5 Other (Specify)	matory or other pla ton Cemetery	y 1	1/26/			ington,	
Baltimore permit. Pages 1 Department of t Important: If it mportant: If it any injury or ot			2. Name and Addre						
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Physician		shock, or heart failure. List enty one cause on each line	1		postpine -		1		Interval Between Onset and Death
/Medical	-	disease or condition resulting in death)  a	para		T	ons			unn
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Box sath cert attendin for use		23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □	Ectopic pregnanc	ey .			2	23d. Date of de Month	Blivery Day Year
Vision of Vital Records, P.O. Box 68 Attending Physicien: The law requires that the death certificate has been signed by the attending pt by the funeral director, page 2 should be detached for use as it flication: To Be Completed by Physician/Med		1   Yes 2   No 9   Unknown	Other (specify) _						
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•ndin •ndin or: Aff		2 Accident investigation		Yes 2	No				
Division of Vital Records, tall or Attending Physician: The law requires t is after death.  al Director: After this certificate has been signed in by the funeral director, page 2 should be Certification: To Be Completed by		3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office		2	8f. Location (S City or Tow			Rural Route Number,
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a)		30. Name and address of person who completed cause of death (ftem 23a) (Type.	Print) Health C	antar	Deiv	e Roud	_ M	n 2071	6
State		31. Date filed (Nonth, Day, Your) 32. Registrar seignature and		CIICCI	או וע	C DOMI	ا'ا و ت	J 20/1	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death PEARL GORDON DeTOBER Day D Physician/ De 10 7:09A M Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner HOSPITAL BALTIMORE NORTHWEST CENTER RANDALLSTOWN If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 216-24 Months Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Funeral 5704 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes. specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Yes 2 No 21215-0036 1 ☐ Yes 2 ☐ No Specify. If Yes, Give Year or Dates 3 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Private Elementary/Seconday (0-12) College (1-4 or 5+) Nurse Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Holman ones John 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau husbar 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location Cemetery, crematory or other places
WOOD dawn Cemeter crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Figural Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Appro imate Onset and Death NEUMONIA. Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events the burial-transi Due to (or as a consequence of): resulting in death) Last physician Physician/Medical The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown Yes 2 No signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by FAILURE ACUTE RENAL Division of Vital Records, 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? O ROPHARYNGEAL 24a. Was an has autopsy performed? Yes 2 No CEREBROVASCULAR 1 Yes 2 No certificate or Attending Physician: 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital Other: 은 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death completed filled in by the funeral 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: \_ 28c. Injury\_at After t 28d. Describe how injury occurred 5 Pending To the Hospital or Attendi within 24 hours after death To the Funeral Director: A 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State, Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier License number 42723 29d. Date signed (Month, Day, Year)
OCTOPER 30 TH town 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5401 ROAX 21133 OLD COURT 0 NORTHWEST HOSTITAL CENTER RANDALLSTOWN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #17 Beate Hi Man Pantil/Dand mut of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Halo Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 1400 Potomac Baltimore St. 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Oonth, Day, **Funeral** last birthday Days 1 M 2 X Hours **Director** permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County City, Town or Location 10d. Inside City Limits Director 1 Ses 2 No 10e. Str and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Was Decedent Ever in U.S. Armed Forces? 12 Yes 2 No 11 Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business Industri (Specify only highest grade completed) Elementary Serongay (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Precious Hale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or mene 20a. Method of Disposition 20b Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) DINGS Milk 21. Signature of Funeral Service Licensee MO155 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician, Onset and Death Multi-inferct disease or condition resulting in death) Dementia 5 years Medical Due to (or as a consequence of): Examiner Stokes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Peripheral Vasculer resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial∹ Physician/Medical 7104001 Diabetes Division of Vital Records, P.O. Box 68760 IF FEMALE: outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death Month 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by I Depression 1 Yes 2 No 3 Probably 4 Unknown Runal insufficiency 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဂ္ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending Accident Investigation 6 Could not be 24 hours after dear 3 ☐ Suicide 4 ☐ Homicide within 24 hours after de To the Funeral Directo completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10/29 2010 00023327 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5+. # 7143 Ashar 31. Date filed (Month, 2010 32. Registrar's S State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Louise Stella Hamer 10 30 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Tewn, or Location of Death 4c. County of Death Examiner Ba HIMONE Dital Kosedale 8. Date of Birth (Month, Day, Year)
Sept. 19,1920 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 ☐ M 2 🖾 F 214-14-3320 90 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show r than "natural", or items 23a or 28a-f shov the Medical Examinat must be notified at 1 ☐ Yes 2 🖾 No Director MD Baltimore Edgemere 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7405 Chesapeake Avenue 21219 United States permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Wedical Examinet must once. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 21☑No Specify. þ Specify: 3₺ Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Years Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) Unkn. 17. Father's Name (First, Middle, Last) Be Andrew Iwanowski ပ 19a. Informant's Name/Relationship (Type. Print) (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Sandra L. Offerman Edgemere, Maryland 21219 7405 Chesapeake Ave. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ¥EABurial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 11/3/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Pert1. Enter the disease ocomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** bleea /Medical Examiner ahodena Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): sician and burial-trans Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) cate has been signed by the page 2 should be detached in <u>о</u> 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ੬ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate 2 1 No Division of Vital 1 ☐ Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No After this Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural To the Hospital or Attervums within 24 hours after death.

To the Funeral Director: Aft 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Franklin Square Drive Bathmore Sheardan 9000

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ 8500 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospital Center Westminster Carrol1 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours Min. (Month, Day, Year) C • 11 • 1922 England Director 215-30-6395 87 Dec. Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director MD 1 🗆 Yes 🔀 💢 No Carro11 Hampstead 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral 1211 N. Main Street Apt. 103 21074 Enqland 12, Was Decedent Ever in U.S. Armed Forces?

1 Yes XX No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: "natural", XXWidowed 4 □ Divorced White Completed Year or Dates ed other than "nature event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. 12 Factory Worker Maryland Cup Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ည permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e Frank Ball Lillian Perry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David J. Hammond / Son 2802 Bachman Ct. Manchester, MD 21102 20b. Place of Disposition (Name of cemetery, crematory or other place)
Baltimore 20a. Method of Disposition 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State ional Cemetery 11/8/10 Baltimore, MD. 4 Donation Other (Specify) 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. Signature unal Service Licensee 11605 Reisterstown Rd. Owings Mills, MD21117 arc 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final enysician/ Orone disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events the burial-trar Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed . Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy death? 2 - No 1 🗌 Yes 1 Yes 2 24 hours after death.

e Funeral Director: After this certific aleted filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 No Other: မ 1 Yes ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 🗷 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 29b. Signature and title of certifie License numbe 29d. Date signed (Month. Day, Year) nd address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2010 October RICHARD HARRISON Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE CO 844 N. MARLYN AVENUE ESSEX Social Security Number If Under 1 Year Months Days 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral 6. Sex 14 M 2 □ F Hours Min. JULY 4 1939 SOUTH CAROLINA 71 Director 250-58-4102 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State Director 1 🗆 Yes 2 🔀 No **ESSEX** BALTIMORE CO MARYLAND 10f. Zip Code 10q, Citizen of What Country? 10e. Street and Number Funeral U.S.A. 21221 844 N MARLYN AVE. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2XXMarried 1 ☐ Yes 2XXNo Specify: If Yes, Give Year or Dates. Specify: BLACK Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) CONSTRUCTION HEAVY EQUIPMENT OPERATOR permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other any injury or other traumatic event, the onee. 6th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ VIRGINIA SHAW RICHARD HARRISON SR. 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 844 N. Marlyn Ave., Baltimore, Maryland 21221 Tyra Molden/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1XX Burial 2 Cremation 3 Removal from State BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 11-04-10 KING MEMORIAL PARK WILL 1206 CLIAM C BROWN COMMUNITY FUNERAL HOME P.A. of Funeral Service Landee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 the for use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Vear Pregnant at time of death g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by EMBOUSM 2 No 3 Probably 4 Unknown 1 🗌 Yes Division of Vital Records, TRIDNEY DISEASE 24b. Were autopsy findings available prior to completion of cause of 24a, Was an page 2 s autopsy performed death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) Hospital: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28c. Injury at work? 1 ☐ Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending 2 🗆 No n 24 hours after death.

le Funeral Director: Al oleted filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier

Registrar

State

completed

within 2 To the F

(Check

only one)

3

29b. Signature and title of certifier

cause of death (Item 23a) (Type, Print)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

PL. BAUTIMORE MD 21202

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 | | | 34241 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 300 M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7978 Phirne Road East Glen Burnie Anne Arundel Co. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Yea Months Days Min 1 M 2 F Hours Yrs Director 217-40-5055 1942 Virginia Usual Residence of Deceden show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene.
 It arti. If if iew 27 is marked other than "natural", or items 23a or 28a-f sho larty or other traumatic event, the Medical Examiner must be notified at Jury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🕅 No MD <u> Anne Arundel Co</u> Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 7978 Phirne Road East 21061 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 □ No If Yes, Give Year or Dates. þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White Completed 3 Widowed 4 Divorced th and Mental Hygiene.

If is marked other than "natura traumatic event, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Maryland State Trooper Law Enforcement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ John W. Hranicka Mary Ε. Poole 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Anne Marie Hranicka /wife 7978 Phirne Road East Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1:
Department of I
Important; If it
any injury or of 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Veterans Cemetery Nov. 3, 2010 Crownsville, MD 22. Name and Address of Facility Singleton Funeral & Cremation Services PA; 1 2nd Ave SW; Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus on each line. Approximate Interval Between Onset and Death Immediate Cause (Final OF THE SMALL INTESTINE ARCINOID Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and signed by the attending physician and d be detached for use as the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Yes 2 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗀 Yes 2 Ko Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 🗌 No Accident Investigation ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Excertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 3 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 44838 30. Name and address of person who completed cause of death (Item 23a) (Ty

Registrar

DHMH 17 Rev 7/2009

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menaei namson		State of Maryland / Department of Certificate of Ce			2010 g. No.	34242
Physicia Medical Examir	ın/	1. Decedent's Name (First, Middle,Last)  Michael Harri:		2. Date of Death Month October 30	n Day Year	3. Time of Death 1700 hrs
		4a. Facility Name (if not institution, give street and number) St. Agnes Hospital	4b. City, Town, or Location of Baltimore		4c. County of Death	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)  216-90-9204 1 2 F 48 Yrs	If Under 1 Year If Under Months Days Hours	Min. Aug • 9	h(MM/DD/YYYY) 9. Bird Foreig , 1962	
daryland 28a-f show any 1 at once.	tor	Usual Residence of Decedent  10a. State  10b. County  Anne Arundel  10c. City, Town or Locat	Glen	Burnie		10d. Inside City Limits  1X Yes 2 No
ith the Maryland 23a or 28a-f sho notified at once.	I Director	361 Gatewater Court, # 402	10f. Zip Code 21060	10	g. Citizen of What Cour USA	itry?
hours after death with the Maryland natural?, or items 23a or 28a-f she Examiner must be notified at once	by Funeral		as Decedent of Hispanic Origi 'es, specify Cuban, Mexican, Yes 2 No specify:		14. Race - Amen White, etc. Specify: Whi	
77	Completed b		nt's Usual Occupation (Give k nost of working life. DO NOT u Bartender		16b. Kind of Business/li	ndustry
	Be Cor	17. Father's Name (First, Middle, Last) Oliver Harrison		s Name (First, Middle, M Peggy Am		
MD 2121 nd 2 should be fi alth and Mental m 27 is marked aumatic event,	٥	T M	g Address (Street and Numb Gatewater Cou			
re, rest land frealt frealt lifem		20a. Method of Disposition  1 Burial 2 *Cremation 3 Removal from State Final Jour	sition (Name of cemetery, her place) rney Crem.	Date 11/4/2010	20c. Location - City or Woodbine,	Town, State MD
Balt permit. Depart Import		21. Signakore of Runeral Service Licensee Dorota Marshall 22. N	Name and Address of Facility Maryland PO Box 14	Cremation 13, Balti	Services more, MD	21203
Physician Examiner		failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of): $Hypot$	complicated			Between Onset and Death
	je.	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):	- Inclinita			
uted id ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last    c. Due to (or as a consequence of):  d.				
760, Toate be executed physician and the burial - transii	ledical	X UNPENDED AMENDED 23a,27,28a-f,per M	E g910 12/13/	10 TT	Lood Date of dall	
Box 68760, e death certificate be the attending physic ed for use as the buried		past 12 months?	etal death 3 Ectopic her (Specify)	pregnancy	23d. Date of delivery  Month  D	ay Year
i, P.O. E ires that the signed by the	ক্র	Part II. Other significant conditions contributing to death but not resulting in the u	ınderlying cause given in Par		pacco use contribute to t	_
cords law requi	Completed			24a. Was ar autops perform 1 🗸 Yes 2	y prior to coned? death?	opsy findings available ompletion of cause of S
Vital Rec hysician: The this certificate	o Be	25. Was case referred to medical examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ✓ ER/Outpatient		Nursing Home 5 F		
ion of tending Pheath. tor: After t	ation:	27. Manner of Death  1 Natural 2 X Accident  28a. Date of Injury (Month, Day, Year) Fd 10/30/10 Fd 2:0	4 🗀 🗸 - a 🗓		ow injury occurred to creek	
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street (Specify) Creek	et, factory, office building, etc.	28f. Location (St or Town, Sta Halethor	reet and Number or Rur ate) 5101 E D: pe ,MD	
To the Hospital within 24 hours. To the Funeral completely filled	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occur (Check only one) 2 Medical Examiner: On the basis of examination and/or investigated and manner stated.				
F > F 5	ž	29b. Signature and title of certifier  Wolf one The Usell	29c. License number O.C.M.E.		29d. Date signed (Mon October 31, 2010	
le pend			enn Street, Baltimore,	MD 21201		
Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature	barker			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010<sup>ear</sup> 27 1815 Alvin James Houston Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City. Town, or Location of Death **Baltimore** Randallstown Seasons Hospice 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Sex M☐ M 2 ☐ F Months Hours Min (Month Bay Year) MD Director **218-42-722**8 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Baltimore MD n/a 1 √2 Yes 2 □ No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral 23a with 21239 6752 Glenkirk Road USA items 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: African-American 1 ☐ Yes 2 X No Specify: If Yes, Give and Mental Hygiene. 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) MD.Dept. of Public Safety& Elementary/Seconday (0-12) College (1-4 or 5+) Correction Services 12th <u>Captain</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Carrie Carter James Houston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important; If item 27 is any injury or other tra Stephanie Houston/Wife 6752 Glenkirk Rd., Balto. MD 21239 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Donation 2 ☐ Cremation 3 ☐ Removal from State 2 ☐ Donation 5 ☐ Other (Specify) Pikesville, MD Druid Ridge Cemetery 11-3-2010 21. Signal re of Funeral Service Licensee Tylie Funeral Home P.A. of Balto. Co. 22. Name and Address of Facility 9200 Liberty Road, Randallstown, MD 21133 Approximate Interval Between Onset and Death 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as card ac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ 5c disease or condition resulting in death) mond Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last physician a sthe burial-t Physician/Medical e attending phys... Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Yes 2 No ed by the a 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by 23e. Did tobacco use contribute to the cause of death? ۾| Division of Vital Records, 2 ☐ No 3 ☐ Probably 4 ☑ Unknown cate has been signated by page 2 should by Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 2 X No 2 🗌 No Yes funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Dother (Specify) 1 Yes 2 1 No 욘 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending e Funeral Director: Af pleted filled in by the fu 1 Yes 2 🗌 No Investigation 6 Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical 1/2 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie within 24 hour To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature 28/ DO043375 2010

Registrar

DHMH 17 Rev 7/2009

State

30. Name

31. Date filed (Month, Day, Year,

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(Itam 23a) (Type, Pri/it)

cause of dea

32. Registrar's Signature

MORNET

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 = For State Registrar			ertificate of			Reg. No.	0 34244	
	Physicia	an	1. Decedent's Name (First, Middle, La					2. Date of Dea	Day	Year 3. Time of Death	
	/Medic	al	Hartzell Leroy I			45 05 7		October	29, 201		
	Examin	er	4a. Facility Name (If not institution, giv Harford Memorial				or Location of Deal le Grace	1	Harf		
	Eupoval		5. Social Security Number 6. S		(In yrs. last birthda	y) If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h		
	Funeral Director		5. Social Security Number 212-14-1077    Usual Residence of Decedent   Country   Count							Maryland	
	yland		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits	
	a-fel	io	Maryland Harfor	rd	Darling	ton				1 ☐ Yes 2 🛣 No	
	or 28	Director	10e. Sireet and Number			10f. Zip Code			10g. Citizen of W	hat Country?	
	ath w		2410 Shuresville			2103			USA		
	er de	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 1	<ol> <li>Was Decedent of F If Yes, specify Cub</li> </ol>	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race Black	- American Indian, c, White, etc.	
Baltimore, Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mentel Hygiene. Item 27 is marked other then "netural; or items 23s or 28s-f ehow other traumatic event, the Muclical Exactivation than rediffied at	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 XYes 2 ☐ No If Yes, Give Year or Dates:	2	1 ☐ Yes 2 🔀 No	Specify:		Specify:	White	
2-(	72 h	ete	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a. De (G.	cedent's Usual Occup ive kind of work done b. DO NOT use retire	pation during most of wor	rking	16b. Kind of Bus	siness/Industry	
121	within ane. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	.)				Chool 1	10001foctures	
20	Hygie ther ant, II		17. Father's Name (First, Middle, Last,	)	<u> </u>	rane Opera		ne (First, Middle,	Maiden Surname	Manufacturer	
an	ould be Mentel arked o	To Be	Robert Cochran He	_				ivia Pri		,	
<u>Z</u>	2 should and Men is marks aumatic	-	19a. Informant's Name/Relationship (		19b. Ma	ailing Address (Street	I			State, Zip Code)	
Ž	alth all		Troy Hewitt / Son	n	443	0 Conowing	o Road	Darlingt	on, MD 2	21034	
ore,	of He of He roth		20a. Method of Disposition	TD	20b. Place of Dis	sposition (Name of rematory or other pla		Date		City or Town, State	
<u><u>ĕ</u></u>	Page nent ant: If ury or		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Darlingt	on Cemete	ry   11-	-2-10	Darlingt	on, Maryland	
Balt	permit. Pages 1 and 2 Depertment of Health a Important: If item 27 is eny injury or other tra once.		21. Signature of Funeral Service Licer	nsee /		22. Name and Addre	uneral Ho	ome, P.A		21000	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the	he death. Do not	1317 Coke				Approximate	
	Dharistan		shock, or heart failure. List only Immediate Cause (Final	one dause on each line		/		- //		Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	a. Scot	consequence of):	Caval	oney of	ta Tuy	<u></u>		
	Examiner				consequence or,		V				
		ner	Sacuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	consequence ot):		~				
	cuted	Examiner	that initiated events	c							
68760,	ficete be executed physicien and is the burial-transit		resulting in death) Last	Due to (or as a	consequence of):						
876	physic the b	edicai		d							
, ×	death certifications attending a		IF FEMALE:	23c. If yes, outcome of	f pregnancy	20,50			22d Date	of delivery	
Вох	atten atten I for u	clan	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth 2 4 ☐ Pregnant at ti	Felal death	3 □Ectopic pregnancy 5 □ Other (specify) _	1		Mon	of delivery th Day Year	
0	that the de led by the a detached t	Physician/M	1 ☐ Yes 2€ No 9 ☐ Unknown	9□ Unknown							
Д.	s that ned b	by Pi	Part II. Other significant conditions of	contributing to death but	not resulting in the	underlying cause giv	en in Part I.	23e. Did to	bacco use contri	bute to the cause of death?	
Ž Š	w requires that been signed b should be deta	pa pa						1 🗆 Y	Yes 3 No 3 Probably 4 Unknown		
Division of Vital Records,	e law re has bee	plet						24a. Was	an 24b. W	/ere autopsy findings available	
A. W.	The I	Be Completed	p					perfo	artopsy prior to completion of cause of death?  s 2 □No 1 □ Yes 2 □No		
/ita	Physicien: Th this certificate ral director, pag		25. Was case referred to medical examiner?				26. Place of Dea	ath  Check only o			
£ .	Physic this o	P	1 ☐ Yes 2 No	Hospital:			4 U Nursing n		lence 6 Othe		
ב ב	ding P h. After t funera	<u>io</u>	27. Manner of Death  1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time Injur	y Wo		28d. Describe h	low injury occurre	·d	
Sign	death.	cat	2 Accident investigation 3 Suicide 6 □ Could not b	e One Place of laive	v - At home form	M 1 □	Yes 2 No	20f Location /6	Stroot and Alumba	or or Rural Route Number.	
S S	s after death	Certification:	4 Homicide determined	building, etc.	(Specify)	street, factory, office		City or Tow	m, State)	r or nural Houle Number,	
	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. within 24 hours after death. To this Funaral bliector: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medicai (	29a. Certifier Certifying Ph (Check only one)	nysician: To the best of niner: On the basis of e and manner state	examination and/or	ath occurred at the ter investigation, in my o	me, date and place ppinion, death occu	, and due to the orred at the time,	cause(s) and mar date and place, a	iner as stated.  nd due to the cause(s)	
	o the	Me	29b. Signature and title of certifier	and mainer state		29c. Licens				(Monthy Day, Year)	
	⊢s⊢ö		10-5	MA		P	6076			9/10	
- , , í			30. Name and address of person who	completed cause of dea	ath (Item 23a) (Tvo	e, Print)	6076 Chesaj		0	7 / 1 .	
611			Muhammuel.	Tothada	v 50.	o Upper	Chesaj	er to	01,15	el Air, MO	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar	's Signature	Ned					
àt !	Registr		NOV 0 3 2010	Consula	p. Agar						
DHI	MH 17 Rev 1/20	001									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene 34245 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER 30°, 2010° ALDEN WALLACE HYDE 3:32 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE @ GBMC TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | NOV • 20 , Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Months Year 1929 Canada 038-20-5243 80 Director Yrs Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Maryland 1 Yes 2 No Harford Bel Air 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral 603 Mapleview Drive 21014 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural" Completed 3 Widowed 4 Divorced White Year or Dates other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Logistics Supervisor U.S. Government Be permit. Page 1 and 2 should be filed. Department of Health and Mental His Important! If item 27 is meriany injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Horace Hazard Hyde Ella (nmn) Beck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Hyde / Wife 603 Mapleview Drive, Bel Air, MD 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Memorial Gdn 11-3-10 Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee McComas funerally Home, P.A. 317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 12ail Sequentially list conditions, Examiner any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transil that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Year Day Pregnant at time of death 2 No g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy **Director:** After this certificate It in by the funeral director, page Yes 2 No 1 Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) Hospital 2 × No Other: 1 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 M Other (Specify) HOSPIC 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 🔼 Natural 5 Pending 1 Yes 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Homicide within 24 hours a

To the Funeral C Medical 29a, Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗌 Certifying Nunse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) D71040 october 30 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARLES 21804 TOWSON MYD

DHMH 17 Rev 7/2009

State Registrar KUMAR

31. Date filed (Month, Day, Year) NOV 03 2010

32. Registrar's Signature

STREET

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 Physician/ BERTHA ELEANORA HYNSON 12:38 A M November 1 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 1610 Clarkson Street Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕱 F Days 220-01-4209 **Director** Maryland Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Maryland N/A 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21230 1610 Clarkson Street USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces ģ 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No If Yes, Give Maryland 21215-0036 1 Yes 2 X No Specify. Specify: Completed 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Housewife & Mother Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname)
Eleanor Kraus 17. Father's Name (First, Middle, Last) John Kline 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Son/Executor) Calvin E. Hynson 1010 First Street, Glen Burnie, Maryland 21060 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery Nov 5, 2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Fungral Service Licensee Kevin E Ecker 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Ave., Balto., Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by ASCUL AV Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? ☐ Yes 2 🗹 No within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 <u></u>3 <u></u>

Registrar

State

6701

and address of person who completed cause of death (Item 23a) (Type, Print)

Bruc

32. Regia rar's Signature

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

M. Charles St

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 6:00 AM ever Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Regional Hospita Laure aure Prince George's 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 XM 2 □ F Min. Hours (Month, Day Director Yrs Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 27 is marked other than "natural", or items 23a or 28a-f s traumatic event, the Medical Examiner must be notified 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Force Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Divorced 4 Divorced Specify: Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainmast. Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 19a. Informant's Name/ - lationship (Type, Print) 9b. Mailing Address (Street and Number or Ru I Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of Date V 1 20c. Location - City or Town, State ☐ Burial 2 XCremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Fundamental Service Licensee 22. Name and Address or 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or head failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final nset and Death Cancer Ph sician/ Pancreas of disease or condition months Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit **Hospital or Attending Physician:** The law requires that the death certificate be executed 24 hours after death. Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chronic Obstructive Pulmonary Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Atrial Fibrillation 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ▼ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 XNo 1 Yes မ 1 💢 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident Suicide Investigation To the Hospital or Atte within 24 hours after de.
To the Funeral Director completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laurel Bowie Rd., Suite 208 14333 20708 Syed Sadia,

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

. .

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #8 per FH G909 11/5/10 TT State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year <u>Joseph Wade Hampton,</u> Medical October 0 2010 1:55 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death <u>Gilchrist Hospice</u> Towson B<u>altimore</u> 8. Date of Birth 3/9/1929 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** If Under 24 Hrs. Birthplace (State or Foreign Country) 1 **★**M 2 □ F Months Days Hours Min Director 217-22-6559 81 Maryland Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland iment of Health and Mental Hygiene.
 It after If 12 marked other than "natural", or items 23a or 28a-f show lury or other traumatic event, the Medical Examiner must be notitied at Jury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 🗆 Yes 2 🕱 No MD Calvert Chesapeake Beach 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20732 3230 Mears Bend USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force Black, White, etc. Completed by 1 Never Married 2 Married 2 Kd No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 - Widowed 4 - Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Trucking 9 <u>Truck Driver</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Evelyn Winkle Joseph Wade Hampton, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chesapeake Beach, Md. 20732 Fay Hampton Wife 3230 Mears Bend 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of F
Important: If ite
any injury or oth 20c. Location - City or Town, State 1 🖔 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place, Park Cemetery 11/3/10 Baltimore, Maryland 21. Signature of Funeral Service Lic-22. Name and Address of Facility Loudon Park Funeral Home <u>3620 Wilkens Ave. Baltimore, Maryland</u> 23a. Part 1. Enter the disease, or conshock, or heart failure. List only blications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. nterval Betweer Immediate Cause (Final Physician/ Onset and Death vauca disease or condition ros Medical resulting in death) Due to (or as a consequence of) . Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending abused and cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death Month Day Year Yes 2 🗆 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 🔀 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Specify) 27. Manner of Death Certificate: Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 🔀 Natural injury 5 Pending Accident Suicide М 2 🗆 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gertifying Murse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) of certifie 29b. Signature and title 29c. License number Pay, Year) MD 71040 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARATHI KUMA 6701 Towa 21204 31. Date filed (Month, Day, Year) 32. Registrar's Si State 2010 Registrar

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 30 Month OCTOBER Physician/ Cheryl Ann Heckler 2010 00:52a™ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) ine 24, 1958 1 □ M 2 🔽 F Country) 52 **Director** 215-72-2486 Baltimore, Marylam Usual Residence of Decedent 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location or other traumatic event, the Medical Examiner must be notified at Director 10d. Inside City Limits Maryland Harford Forest Hill 1 Yes 2 XNo 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 803 Delray Drive 21050 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. Armed Forces HERYL Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 ☐ Yes 2 🔀 No Specify: "natural", 3 Divorced 4 Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Marketing Insurance Be 17. Father's Name (First, Middle, Last) aryland 18. Mother's Name (First, Middle, Maiden Surname) ၉ Harry Glos Ruth Elaine Frederick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health: Cary Heckler (Spouse) 803 Delray Drive Forest Hill, Maryland 21050 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 once. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Moreland Memorial Park Nov. 2, 2010 Parkville, Maryland 21. Signature of Plineral Service Licensee

22. Name and Address of Facility

Figure Funeral Chapel & Crematice

800 Harford Road Parkyille, M

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart allure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of): 22. Name and Address of Facility
Fixens Funeral Chapel & Cremetican Services—Parkville
8800 Harrford Road Parkville, Maryland 21234 Interval Between Onset and Death Ph sician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cauce. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death the þ signed I Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b lirector, page 2 s autopsy perform 1 Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗆 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral dir 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at I Director: After to d in by the funera 28b. Time of 28d. Describe how injury occurred Natural work?
1 Yes 2 No 5 Pending 2 Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD completed cause of death (Item 23a) (Type, Print) 32. Registrar Sign State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () 34250 State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ REV. DR. ROBERT T. HURTE 12:30p M OCTOBER 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death UNION MEMORIAL BALTIMORE HOSPITA 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 6. Sex. 1 M 2 □ F 8. Date of Birth (Month, Day, Year) 228-38-5808 78 **Director** VIRGINIA 7-20-1932 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a State 10c. City, Town or Location 10d. Inside City Limits Director BALTIMORE 1 XYes 2 No MD. TOWSON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21286 USA 831 PROVIDENCE RD. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 K Married Completed by 1 X Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 BLACK 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) -12-MINISTER RELIGION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ETHAN FORD ROBERT L. HURTE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) IDA HURTE(WIFE PROVIDENCE RD. TOWSON, MARYLAND 21286 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 9 3 🗀 Removal from State cemetery, crematory or other place! remation 4 Donation Xour (Specify) ENTOMBMENT DULANEY VALLEY MEM. 11-6-2010 TIMONIUM, MARYLAND . HIBN R<sup>2. Name and Address of Facility</sup> PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Interval Between Immediate Cause (Final et and Death Physician/ Aspiration Medical resulting in death) Examiner Cancel etastati MONTH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year Pregnant at time of death Yes 2 No ed by the a 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by has been sig 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate ha performed? Yes 2 KNo 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital Other: မ 1 Yes 2 No 1 Inpatient 2 K ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Cartifying Nurse Practionar: It this best of my knowledge, chall populated at the time, late and place, and due to the cause(s) and ma ner as stated. nity and 29,2010 DOO63657 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21218 Ste. 136 Dr. Craig 200

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State Registrar 31. Date filed (Month, by, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 29<sup>Day</sup>  $10^{
m th}$ 20ÎÛ Frances Innocenti. 12:45 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Burtonsville Holy Cross Nursing & Rehab 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Ohio Days Hours Min. 1100 131 19ar **Director** 90 280-70-3681 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Directo 1 Yes 2X No Clarksville Maryland Howard 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral items 23a U.S.A. 21029 5907 Gentle Call filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 0 1 ☐ Yes 2 🗶 No If Yes, Give Year or Dates. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. "natural", Specify. White 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Menswear Seamstress or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked Giovanna Zelko Anton Kuret 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5907 Gental Call Clarksville, Maryland 21029 Roberto Innocenti (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 X Removal from State 11/04/2010 Chardon, OH 4 ☐ Donation 5 ☐ Other (Specify) All Souls Cemetery 21. Signature of Funeral Service License Witzke Funeral Romes, Inc. Columbia, Maryland 21045 5555 Twin Knolls Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Advanud Demenh disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: ves, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year g Unknown P.O. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 00054566 10/29 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9801 Creongia Arnu # 17, Silverspains Sunista Bhogavyli, 31. Date filed (Month, Day,

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State Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - State of Maryland / Department of Health and Mental Hygiene Certificate of Death  Certificate of Death  Reg. No. 2010 34252									
			Decedent's Name (First, Middle, Last)								
Physician Medica			GENEVIEVE G. IRVII		Month C						
	Examin	er	4a. Facility Name (if not institution, give street and number)  122 Chelsea Grove Court	4b. City, Town, or Location of Death Pasadena		4c. County of Death	1 - 1				
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birth	runde 1 place (State or Foreign				
	Director		232-34-2533 1 □ M 2 F 82 Yrs.	Months Days Hours Min.	07/15/19	928 Cour	WV WV				
	nd thow at	'n	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or L	ocation		1	10d. Inside City Limits				
	Maryla 18a-f tified	Director	MD Anne Arundel	Pasaden	.a		1 ☐ Yes 2 🛣 No				
	aor2 aor2 beno	Ē	10e. Street and Number	10f. Zip Code	10g.	. Citizen of What Cou	ntry?				
	th with ms 23 must	by Funeral	122 Chelsea Grove Court	21122		U.S					
(0	er dea or ite niner		11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Never Married 2 ☐ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White,					
g	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	ed b	3 Widowed 4 □ Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 🕅 No Specify:		Specify:	White				
<u>5</u> -	72 hou "nat ledica	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation kind of work done during most of worki	ng 16b	o. Kind of Business In	dustry				
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E E	Page 1 nent of ant: If i			matory or other place) 11 Cemetery 11/0		Brooklyn I					
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	2. Name and Address of Facility 1	2nd Ave,	SW Glen	Burnie, MD				
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	Ph <sub>_</sub> sician/		shock, or fleat failure. List only one cause on each line. Immediate Cause (Final disease or condition	uctive Pulmon	ary D	800 60	Interval Between Ors and Death				
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	e exectian an	a Ex	resulting in death) Last Due to (or as a consequence of):								
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0 00	nding ath. :: After e fune	icate	1 Matural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation	work?  M 1 Yes 2 No	28d. Describe how in	ijury occurrea					
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	To the Hospital or Attending Physician: The law within 24 Hours after death.  To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 e	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
	Vithi Vomp		29b. Signature and title of certifier	29c. License number		Date signed (Month)					
	,		Spream M. Neegle, MM	1044838		1/01/1	0				
	5		30 Name and address of person who completed cause of death (Item 23a) (Type, SUSAN H. KRIEGUR, MD HE	- Defense Hwy	Annapo	·Cis MD	21401				
	Stat Registra	_	31. Date filed (Month, Day, Year) NOV 0 3 2010 32. Registrar's Signature	estel		7					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month HODE GLORIA JOHNSON 08.02 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Bay view Medical Cente Baitmore N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Social Security Number 9. Birthplace (State or Foreign 1 □ M 2 💢 F 216-42-3129 65 Director 1945 Feb. Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD N/ABaltimore 1 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4803 Greencrest Road 21206 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2XXNo Specify: 3 XWidowed 4 ☐ Divorced Specify: Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Nurse Technician Sinai Hospital years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Julian Buster McMiller Rebecca Powell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Zoe Matthews/ Daughter 4816 Bowland Avenue Baltimore, MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 11/1/10 Pikesville, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral 4210 Belair Road Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nset and Death Immediate Cause (Final Physician/ Hypovolemia disease or condition aL Medical resulting in death) Examiner hrom bocy to penia week Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events southing indepth Leat Examine Metastatic colon cancer 25 years Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident 3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2

To the 29c. License number 29d. Date signed (Month, Day, Year) Nelun Degre RES-000 October 24, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Dezube MD Eastem Avenue Baltimore MD

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month NSCO hres 00 2:55 A 2 Medical 4a. Facility Name (if not institution, give st 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Fyture Care Boltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth State or Foreign 9. Birthplace **Funeral** 1 🗆 M 2 🔀 F Months Days Hours Min. Director -40-0260 Usual Residence of Deceden ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ehrm any injury or other traumatic avent the state of the state o 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 X Yes 2 No more 10e. Street and Number 10f. Zip Code 10g. Citizen of What 21230 egWord 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race -American Indian. Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industr (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nday (0-12) College (1-4 or 5+) omestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည umm 19a. Informant's Name/Relationship (Type, Print) or Town, State, Zip Code) 19b. Mailing Address (Street and Number Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) -5-2010 21. Signature of Funeral Service Lie 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Masca Physician, asdio Medical resulting in death) to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury mis that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🛣 No
9 ☐ Unknown Pregnant at time of death 5 Other (specify) Month Day Year 4 ☐ Pregnant 9 ☐ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 42 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has autopsy 2 No 1 Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital Other: ၉ 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending death. 2 Accident
3 Suicide
4 Homicide 2 🗆 No 1 Tyes Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 🔏 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year) Asso funds

State Registrar 30. Name and address of person who comp

3 2010

31. Date filed (Month, Day, Year,

32. Registrar's Signatur

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			1- For State Amend Item State of Maryland / Dan Per Verb., g 909	artment of Health and Mental H tificate of Death	Hygiene 2010 34255				
	Physici Medi			2. Date of I OCLOD					
-	Exami	ner	4a. Facility Name (if not institution, give street and number)  Montgomery General Hospital	4b. City, Town, or Location of Death Olney  4c. County of Death Montgomery					
	Funeral Director		5. Social Security Number  578 − 78 − 2469  6. Sex  1 ☑ M 2 ☐ F  7. Age (In yrs. last birthday)  578 − 78 − 2469	If Under 1 Year   If Under 24 Hrs.   8. Date of E					
	aryland a-f show fied at	Director	Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or Lo           MD         Montgomery         Bethesda	cation	10d. Inside City Limits				
	with the Ma 23a or 28 ist be noti	eral Dire	10e. Street and Number 6040 South Port Drive	10f. Zip Code 20814	1 ☐ Yes 2 🔁 No  10g. Citizen of What Country? USA				
9600	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ted by Funeral	1 Never Married 2 Married 1 Yes 2 No	Vas Decedent of Hispanic Origin? (Specify Yes or Not Yes, specify Cuban, Mexican, Puerto Rican, etc.)  ☐ Yes 2  No Specify:	14. Race - American Indian, Black, White, etc. Specify:				
Maryland 21215-0036	within 72 ho giene. er than "nal er the Medica";	Completed		ent's Usual Occupation ind of work done during most of working O NOT use retired)	16b. Kind of Business Industry				
yland	uld be filed I Mental Hy narked oth natic event	To Be	, ,	18. Mother's Name (First, Middle	e, Maiden Surname) unk				
e, Mar	and 2 shou Health and em 27 is n ther traum		Montgomery General Hospital 18101	g Address (Street and Number or Rural Route Numb Prince Phillip Dr; Oln	per, City or Town, State, Zip Code) Ley, Maryland 20832				
Baltimore,	iit. Page 1 irtment of intrant: If it		4 □ Donation 5 ☒ Other (Specify) in state	atory or other place)	20c. Location - City or Town, State				
Ba	permi Depar Impo any ir		simple lies	Name and Address of Facility State Anat 555 W. Baltimore Street;	Baltimore, MD 21201				
	Physician/ Medical Examiner		23a. Pan 1. Enter the disease, or complications that caused the death. Do not enter shock or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	the mode of dying, such as cardiac or respiratory a	Approximate Interval Between Onset and Death				
	cate be executed physician and sthe burial-transit	l Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	Cardievasenta	Vers.				
2/60	ficate be g physici as the bu	Medical	d						
7. BOX 68	swar. The law requires that the death certificate be executed certificate has been signed by the attending physician and frector, page 2 should be detached for use as the burial-transit		F FEMALE: 23b. Was decedent pregnant in the past 12 months?   1 □ Yes 2 □ No   9 □ Unknown   23c. If yes, outcome of pregnancy   1 □ Live Birth 2 □ Fetal death 3 □   4 □ Pregnant at time of death 5 □   9 □ Unknown	Ectopic pregnancy Other (specify)	23d. Date of delivery Month Day Year				
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necords,	within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the atteit completed filled in by the funeral director, page 2 should be detached for the funeral director.	Completed		24a. Was autor perfo	an 24b. Were autopsy findings available prompt to completion of cause of death?				
A 10	his certificate has		25. Was case referred to medical examiner?  1  Yes 2 No  Hospital:  1  Inpatient 2 FR/Outpatient	26. Place of Death (Check only one)	2 No 1 Yes 2 No				
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	/ S P 0		> Golden K- Med Dir- Dept Em	80050410	29d. Date signed (Month, Day, Year)				
	State	_/	30. Name and address of person who completed cause of death (Item 23a) (Type, Prin    1870   Prince     31. Date filed (Month, Day, Year)   32. Registrar's Signature	help be Olmey MD &	20832				
	Registrar	_	18 (18 ) 18						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10/27/ Physician/ Nettie Jefferson 12:50ar Medical 4c. County of Death Baltimore 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Towson Examiner Gilchrist Hospice Center 5. Social Security Number 302–32–1739 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 MS 8. Date of Birth **Funeral** 2/15/39 1 ☐ M 2**X** F Months Days Hours Director Usual Residence of Decedent or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Completed by Funeral Director Pikesville MD Baltimore XX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 16 Old Court Road USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Black Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) CMHA Public Housing Authority Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Be 17. Father's Name (First, Middle, Last) 8. Mother's Name (First, Middle, Maiden Surr Nettie Mae Hollins ဂ္ Jackson James 19a. Informant's Name/Relationship (Type, Print) / Charmaine Jefferson / Daughter ng **Cedar da Le**Numba or Bural Boute Number, Mits or Zw2 fister, Zip Code) <sup>1</sup>3800 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1
Department of I
Important: If it
any injury or o
once. 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Cleveland Mem Gardens Highland Hills OH 4 ☐ Donation 5 ☐ Other (Specify) 11/5/10 re of Funeral Service Licensee Victor Doda <sup>22</sup> Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Ave, Baltimore MD 21230 1US 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nsat and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, it cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to for este nonsequence off Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use, contribute to the cause of death? à Be Completed 1 Tyes No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes Yes 2 4 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 ၉ Nο 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence Director: After this it in by the funeral director 27. Manner of De 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 Yes 2 No 5 Pending 2 Accident
3 Suicide
4 Homicide М Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) within 24 hours af To the Funeral Di completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 — Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature 29d. Date signed (Month, Day, Year) 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

State

Registrar

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32. Registrar Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) Month Physician/ 11:20 2010 October Mildred Anderson Jones Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Jacob's Well Assisted Living Harford Bel Air If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex OCE I **Funeral** Days Hours Min. Pennsylvania ∄915 1 🗆 M 2 🖾 F 95 167-07-6630 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10a. State 10b. County notified at Director 1 🗌 Yes 2 🖰 No Churchville Harford Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō er than "natural", or items 23a of the Medical Examiner must be 21028 Funeral 11 Calvary Road 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Page 1 and 2 should be filed within 72 hours after death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 🛮 Widowed 4 🗌 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) aith and Mental Hygiene. 27 is marked other than "I r traumatic event, the Med College (1-4 or 5+) Elementary/Seconday (0-12) Poultry Farm 12 Farmer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Swartswelder Lillian Mae 2 Frank Howard Miller Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11 Calvary Road, Churchville, Maryland 21028 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trauonce. Priscilla Cockerham / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Aberdeen, Maryland Harford Memorial Gdn 11-3-10 4 Donation 5 Other (Specify) <sup>22</sup> Name and Address of Facility Home, P.A. MCComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 21. Signature of Funeral Service License athlee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between et and Death Immediate Cause (Final deneite Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury as a consequence of) Examiner itulian attending physician and for use as the bunal-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Box 68760 IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy Month in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) been signed by the sahould be detached 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy has performed? Yes 2 N 2 No 1 Yes this certificate 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Assisted Other: 2 No 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tes ြုင Living 28d. Describe how injury occurred . Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: within 24 hours after death.

To the Funeral Director: After completed filled in by the funer work? 1X Natural 5 Pending Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier (7 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DUBYOSKI 615 W Melphan PATRICIA

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

-92. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10 Day 26 Year [ Urban John Kaufmann, Sr. 11:55amm Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Many 1 and **Funeral** 1 🛛 M 2 🗆 F Months Hours Min 03-07-1944 213-42-4679 66 Director Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c, City, Town or Location 10d. Inside City Limits Director Maryland Baltimore 1 X Yes 2 No N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4914 Ross Road 21214 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Driver Clover-Greenspring Dairy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Frederick Kaufmann Anna Probst 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Merenda - Fiancee Ross Road Baltimore, MD 21214 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Hilltop Service Corporation 11-01-2010 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland 21. Signati 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part 1. Exter the disease / r c implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Li to my one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Stage Luko concer disease or condition years Medical resulting in death) Due to (or as a consequence of) Examiner obstructive years Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or linjury that initiated events to the Hospital or Attending Physician: The law requires that the death certificate be executed HUPOXICA hours attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Tobacco Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 ☐ Yes 2 ☐ No Yes 2 To Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No s after death. Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1500183740 M.D. 10/2-6/10

DHMH 17 Rev 7/2009

State Registrar

Jehan David

Battimore MD.

union memorial

PKWY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200 E. University

## State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ernestine Klima Ann 29ª 2010 Oct. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Baltimore Towson If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Feb. 28, 1931 1 □ M 2 🙀 F 218-26-0351 Texas Director Usual Residence of Decedent 23a or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Dundalk Baltimore MD 10f, Zip Code 10g. Citizen of What Country? Funeral 7442 Durwood Road United States 21222 11, Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Force Black, White, etc. þ 1 ☐ Yes 2 🛣 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) State of Elementary/Seconday (0-12) College (1-4 or 5+) Maryland Income Tax Supervisor Years 12 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Leona Fain Ernest J. Collier 19a. Informant's Name/Relationship (Type, Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sr. Mr. Rudolph E. Klima, 7442 Durwood Road Dundalk, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Sacred Ht. of Jesus Cem. 11/1/2010 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State Dundalk, MD ☐ Donation 5 ☐ Other (Specify) ture of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, MD 21222 Sig 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or is a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day 9 Unknown 9 Unknow P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown . Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 XN 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 X No Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 MOther (Specify) Director: After the in by the funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours aff To the Funeral Di completed filled in Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

3:45 A

1 🗌 Yes 2 🛛 No

White

Approximate

Year

OCTUBER 25

DHMH 17 Rev 7/2009

WAV 31. Date filed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) annes

W)

32. Registrar's Signature

N.C.

6701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 34261 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ н. Kent James 2010 8:45 AM October Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Co. Edgemere 7413 Blevins Avenue 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Sept. 26,1926 Months Davs Hours 1 🔯 M 2 🗆 F Pennsylvania 175-20-6617 Director 84 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits be filed within 72 hours after death with the Maryland 10c. City. Town or Location ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 🔀 No Edgemere Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21219 United States 7413 Blevins Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: Specify. 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Steel Industry Millwright h and Mental Hygier 7 is marked other t 12 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev once. ည Rena Commons James H. Kent 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Flagmere Marvland 21219 19a. Informant's Name/Relationship (Type, Print) Edgemere, Maryland 7413 Blevins Ave. Cherie L. Katon (Daughter)

20b. Place of Disposition (Name of

Data

20c Location - City or Town State

October 20, 2010

Ph\_sician/ Medical 20a. Method of Disposition

Baltimore, Maryland 21215-0036

**Examiner** 

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

	1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Denayon ⊅ ☐ Other (Specify)		remetery, crematory r Lady of	or other place) Mercy Cen.	10/30/	'201p	Catawis	sa, P	<i>A</i>		
	21. Signature of ineral Service Lie	From		ne and Address of Facility -Ruck Funera 2 Wise Ave.	1 Home Dunda	of Dune 1k, Mary	dalk, In	nc. 1222			
	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cations that caused the deat cause on each line.  Due to or as a consequence of the cause of the	Hewrt	mode of dying, such as cal	rdiac or respir	ratory arrest,			Between and Death		
edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence)	uence of):	n.							
ıysıcıan/me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown		23d. Date of delivery Month Day								
ed by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.										
completed					_	4a. Was an autopsy performed? ☐ Yes 2 🗷 N	24b. Were au prior to death? 1 \( \sum Yes		of cause of		
ě	25. Was case referred to medical			26. Place of Death	(Check only o	ne)					
0	examiner? 1  Yes 2 No	spital:	EB/Outpatient 3	DOA Other:	ing Home 5	X Residence	Other (Spec	rify)			
erilicate: 1	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work?  M 1 Yes 2 No							
١	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, street, fa	ictory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
Medical	(Check 2 Medical Examine	ian: To the best of my know r: On the basis of examination Practioner: To the best of m	n and/or investigation	n, in my opinion, death occu	irred at the tim	e, date and place	, and due to the	cause(s) and	l manner stated		
	29b. Signature and title of certifier			29c. License number		29d. Da	te signed (Mont	h, Day, Year	)		

State Registrar North

32. Registrar's Signature

Point Rd.

Scellimere,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

·7566

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician/ 19:02 PM OCTOBER 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9 HOSDI Baltimore nes | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Days | Hours | Min. | (Month, Day, Year) | 09/08/1964 9. Birthplace (State or Foreign . Age (In yrs. last birthday) **Funeral** 1 □ M 2 😿 F 217-90-4814 MARYLAND **Director** Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 🗌 Yes 2 X No HOWARD COLUMBIA 10g. Citizen of What Country? 10e Street and Number Funeral U.S.A FOREST ROAD 21045 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11 Marital Status Armed Forces Black, White, etc. ğ 1 Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 Specify: BLACK 1 Yes 2 No Specify Completed 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) D.C. METRO and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) DRIVER MTA Be other traumatic event, permit. Page 1 and 2 should be filed. Department of Health and Mental Himportant! If item 27 is more any injury or other. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ MILDRED Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State)

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19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

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19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) KELL MILDRED MOTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BALTIMORE, MARIJAND 05 2010 22. Name and Address of Facility THE DERRICK C. JONES FIH, P.A uture of Funeral Service BACTIMURE MARY 121215 4611 PARK HGTS. AUE. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final metastatic breast carcinoma Physician/ Widel disease or condition Medical resulting in death) Due to (or as a onsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to for as a consequence of, signed by the attending physician and d be detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 □ Xes 2 □ No Month Year Other (specify) Pregnant at time of death Unknown Unknown Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 2 No 3 Probably Records, The law requires been s 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy 2 🗌 No hours after death. Ineral Director; After this certificate I 2 🗆 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Vital completed filled in by the funeral director, Certificate: To Be examiner? Hospital Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Division of 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 5 Pending Natural 2 Accident Investigation 3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2010 84 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 MM CATON Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Monthober Physician/ Edna May Knapp Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel Co. 8. Date of Birth (*Month, Day, Year*) May 18**,** 1932 9. Birthplace (State or Foreign Country) MD 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 □ M 2 🗓 F Months Days Hours Director 218-28-3808 78 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director iral", or items 23a or 28a-f s Examiner must be notified 1 Tes 2 No MD Anne Arundel Co. Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral United States 310 6th Avenue N.E. 21060 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 X No Maryland 21215-0036 filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Motor Vehicle Elementary/Seconday (0-12) College (1-4 or 5+) Administration Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) P Katherine Pauline Frederick Gause 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 306 6th Avenue NE, Glen Burnie, MD 21060 Mr. Gary W. Knapp / Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) Glen Haven Mem. Park 11/2/2010 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation Signature of Funeral Se Service PA; 1 2nd Ave SW, Glen Burnie, MD 21061 M01121 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ 200 disease or condition Medical resulting in death) Examiner tailuve Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Cause (Disease or iinjury that initiated events resulting in death). Last Physician/Medical Examiner eate has been signed by the attending physician and page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 this certificate 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to/medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No 1 Tyes Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. May er of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred  $5 \square$  Pending Natural work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

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Mame and address of person who completed cause of death (Nem 23a) (Type, Print) 3

32. Registrar's Signature

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31. Date filed (Month, Day, Year)

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 34264 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Michael Earl Kelly October 28, 2010 11:15 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Sep. 12 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Hours Maryland Yrs Director 212-50-5856 Sep. 1949 10b. County 10a. State 10c. City, Town or Location event, the Medical Examiner must be notified at **Funeral Director** 10d. Inside City Limits 1 Tes 2 No <u>Maryland</u> Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 1201 Beechcrest Drive 21014 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ö 1 Never Married 2 Married δ ☐ Yes 2 🕅 No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 ial Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Sales Manager Automotive Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental I ၉ injury or other traumatic Earl Scarborough Kelly Elsie Katherine Cooley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other tractonce. Julia J. Kelly / Wife 1201 Beechcrest Drive, Bel Air, MD 21014 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Dremation 3 Removal from State Hilltop Service Corp. 4 ☐ Donation 5 ☐ Other (Specify) 11-1-10 Towson, Maryland 21. Signature of Funeral Service Licenses McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Severe Physician/ Preumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cardiomyopathy Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Pulmonary hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) 1 Tyes 2 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D63420 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State Registrar

DHMH 17 Rev 7/2009

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		1- For State Certificate of Death	7	F	Reg. No.	
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Medical Exam	ner	Stanley Kazanowski		October 2		1719 hrs
		4a. Facility Name (if not institution, give street and number)  220 S. Chester Street  Baltim	own, or Location of De Iore	ath	4c. County of Deat	h
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Unde	r 1 Year   If Under 24	Hrs. 8. Date of Bi	irth(MM/DD/YYYY) 9. Bi	rthplace (State or
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imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. I fant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once	Be	Joseph Kazanowski	Anna d	Jaworski		
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MD rd 2 sho alth and m 27 is					Maryland 2	
Fe, s 1 an f Hea		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State Crematory or other place)		Date	20c. Location - City or	Town, State
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Baltimore, MD permit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumati	1/4	X- F-X (401 S. 0	. weber fur Chester St	neral Hor reet Ball	mes P.A. timore, Mary	land 21231
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tal Rec cian: The l certificate l ector, page	ខ្ញ			1 ✓ Yes	2 No 1 Y	es 2 No
Division of Vital Records, tal or Attending Physician: The law requirers after death.  al Director: After this certificate has been siled in by the funeral director, page 2 should be	a	examiner?	6.Place of Death (Chec		D. I. D.	
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ivisior or Attend after death Director:	lä.	2 Accident Investigation Oct 28, 2010 1710 hrs 28e. Place of Injury - At home, farm, street, factory,		39f Location /	Street and Number or Ru	ral Bouta Number City
Divi	틥	Suicide Could not be determined (Specific) Davids and	once building, etc.		Street and Number of Ru State) er Street, Baltimore, N	
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1		<ol> <li>Name and address of person who completed cause of death (Item 23a)</li> <li>Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltim</li> </ol>	ore, MD 21201			
	ate	31. Date filed (Month, Day, Year)  32. Registrar's Signature			·	
Regist		NOV 03 2010 Change & Sparled				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month /o Physician/ PANK 2320 Medical 4a. Facility Name (if not institution, give street and no **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SEASONS HOSPICE @ NORTHWEST HOSPITAL BALTIMORE RANDALLSTOWN Social Security Number 6. Sex 1 X M 2 ☐ F 7. Age (In yrs. last birthday) If Under 8. Date of Birth 9. Birthplace (State or Foreign Birthplace Country) MD Funeral Months Hours Min. 89 Yrs 219-12-9170 Director Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland Examiner must be notified at Director 10d. Inside City Limits 1 🗌 Yes 2 🗓 No BALTIMORE BALTIMORE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1450 BEDFORD AVENUE, #203 21208 items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces?
1 X Yes 2 If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. "natural", or Completed by 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 3 🕅 Widowed 4 🗆 Divorced Specify: Year or Dates WHITE marked other than "natur matic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the N College (1-4 or 5+) 12 OWNER FREMONT COAL COMPANY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည KOLMAN KODECK CELIA FAGIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #301 BALTIMORE, MD 21209 DRIVE NED S. KODECK / SON 7400 TRAVERTINE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BNAI ISRAEL CONG. 10/31/2010 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Most 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, isading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed exa Cause (Disease or linjury and burial-tran that initiated events resulting in death) Last the attending physician hed for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Month Day Year 4 ☐ Pregnant 9 ☐ Unknown 9 Unknown cate has been signed by ; ; page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 D Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 2 🗆 No 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospital: HOSPICESHLE ပ 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28c, Injury at work? 1 \sum Yes 2 \sum No 28b. Time of 1 Natural 5 Pending Accident Investigation n 24 hours after deat e Funeral Director: completed filled in by the 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of entifie

DHMH 17 Rev 7/2009

State Registrar s of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

re. #203. Baltim

29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene Or 11/01/2010dhb Certificate of Death Reg. No. 34267 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death LIVINGSTON Physician/ SON 6:15 AM 8.2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Battersea Place Baltimore Hpt. 103 Baltimore 9. Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) 8. Date of Birth **Funeral** Days Min. (Month, Day, 218.26.442 MD **Director** Usual Residence of Decedent or 28a-f show 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at **Funeral Director** Baltimore Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Battersea Mace 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black 3 X Widowed 4 □ Divorced Specify: Year or Dates marked other than "natur matic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Laborer Motors 12th grade Jeneral Hear Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည wingstor Smith onzella 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) D. Livingstz Battersea Place Baltimone ND 21244 Apt. 103 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other i 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 10/16/2010 Windsor Mill, MD King Memoria 4 ☐ Donation 5 ☐ Other (Specify) Vaughy C. Greene Funeral Services 21. Signature of Funeral Service Lisensee 22. Name and Address of Facility Rundallstown MD 2113 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death
UNKNOWN Immediate Cause (Final Physician, disease or condition resulting in death) Medical **Examiner** 16 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last sate has been signed by the attending physician and page 2 should be detached for use as the burial-transi Due to (or as a consequence of): Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Malnutrition \$ severe After this certificate 1 ☐ Yes 2 ☐ No ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending work? injury 2 Acciden Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2010 Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

NOV 0 1 2010

Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: s after death. Funeral To the I within 2.

Registrar DHMH 17 Rev 1/2001

State

29a, Certifier

29b. Signature and title of certifier

77/2eN

Medical

and manner stated.

2835

30. Name and address of person who combleted cause of death (Item 23a) (Type, Print)

MD

ta Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

037573

29d. Date signed (Month, Day, Year)

21508

MD

November 1,7010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 34269 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 15:50 OCTOBER Noreita Marie Ludwig 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Agnes Bal Hospital more 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2XXF Months Days Hours Min (Month, Day, Year) 6/21/193 Director 73 215-34-6004 Usual Residence of Decedent show 10a. State 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at be filed within 72 hours after death with the Maryland 10d, Inside City Limits Director 1 Yes 2XX No MD Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 4514 Robosson Rd. USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 ☐ Never Married 2 🖾 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Year or Dates Specify: 3 Divorced 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. I other than " life, DO NOT use retired) Elementary/Seconday (0-12) 12 Zerwitz & Zerwitz Legal Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F 2 Norman E. Oates, Sr. Hilda Louise Bere t. Page 1 and 2 should by thment of Health and Mer rtant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Albert Leroy Ludwig, Sr./Husbland 4514 Robosson Rd., Randallstown, MD 21133 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or otl Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 11/1/2010 Carroll Crematory Winfield, MD <sup>22</sup> Burrier-Cueen Funeral Home & Crematory, P.A. 2 1212 W. Old Liberty Rd., Winfield, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Physician/ Non small Contex disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy sate has been signed by the atte page 2 should be detached for a in the past 12 months?
1 Yes 2 No Month Year Day 1 Yes 2 J P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Coronar 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? After this certificate 2 No ors after death.

eral Director: After this certification in by the funeral director, itself in the funeral director. To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 1 Tes 2 No 1 Nnpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a

To the Funeral C

completed filled Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature a Resident Medical P23613 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Caton Ave. Baltimore MD 21229

Registrar DHMH 17 Rev 7/2009

State

Nath

31. Date filed (Month, Day, Year)

halise

32. Registrar's Signature

D

NOREI

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Margaret Mary Lincoln October 28, 2010 8:16 AΜ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Bethesda Montgomery Springhouse at Westwood Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 9, 1910 **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🖾 F Months Days Min. 100 060-09-9687 New York **Director** Usual Residence of Decedent show 10a. State 10c. City, Town or Location items 23a or 28a-f sho her must be notified at 10d. Inside City Limits Director Maryland Montgomery Bethesda 1 🗌 Yes 2 🏻 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7601 Shadywood Road 20817 United States filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Margaret Mary Bolger Thomas Leo Delaney Jet 1 and 2 sh.
Jepartment of Health ano
Important: If item 27 is many injury or other 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 316 Old Plantation Road, Jekyll Island, Georgia 31527 Margaret Mary Stock/Daughter 20b. Place of Disposition (Name of cemetery crematory or other place)
Gate of Heaven
Cemetery 20c. Location - City or Town, State Date X Burial 2 ☐ Cremation 3 ☐ Removal from State November 1, 2010 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Robert A. Fumphrey Funeral Home/Bethesda-Chevy 7557 Wisconsin Ave., Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Licensee M00198 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Days Ph\_sician/ Aspiration Pneumonia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 1 Year Inanition Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 🔀 No Month Day Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 A N this certificate 1 Yes 2 🗌 No Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Assisted 1 ☐ Yes 2 🖾 No Other: ည 1 Inpatient 2 I ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔼 Natural 5 Pending work' within 24 hours after death.

To the Funeral Director: Ai completed filled in by the fu 1 🗌 Yes 2 🗌 No ☐ Accident ☐ Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

12

State

P.O. Box 68760

Records,

Division of Vital

32. Registr 's Sign ture

M.D. 5530 Wisconsin Avenue #1400, Chevy Chase, Maryland 20815

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lila T. McConnell,

31. Date filed (Month, Day, Year)

October 28, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #1 Per PHY G909 11/03/10 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Samuel Levine OCTOBER LEVINE 08 30 AM 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death NORTHWEST HOSPITAL CENTER BALTIMORE RANDALLSTOWN If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 08/28/1922 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) **Funeral** 1√ M 2□ F 093-14-3945 88 Director NY Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show 1 □Yes 2 □ No Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1459 BEDFORD AVENUE, #418 21208 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. hours after 1X1Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 72 Elementary/Secondary (0-12) 12 College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 Is marked other the any injury or other traumatic event, Ilm. Once. REALTOR REAL ESTATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be KUNE LEVINE IDA 2 UNKNOWN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KARROL KOWITZ/DAUGHTER 5509 WEYWOOD DRIVE, REISTERSTOWN, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State MARYLAND VETERANS CEM 11/04/2010 OWINGS MILLS, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Signature Funeral Service Licer 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or sent shock, or heart failure. List only complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): Box 68760 attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) signed by the a I be detached f □Yes 2□No Ö 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 CHROMIC KIDSVEY ATRIAL FIBRILLATION 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed MELITUS, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Hospital or Attending Physician: The certificate TENSION 1 □Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 📉 No 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA completely filled in by the funeral 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death 2 Accident after death 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

e Funeral i within 2 To the the

> State Registrar

CAMASWAMY 31. Date filed (Month, Day, Year) 2010

29b. Signature and title of certifier

(Check only one)

RANGARAJAN 32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NORTHWEST HUSPITHL CENTER

29d. Date signed (Month, Day, Year)

2010

Octuber 25

29c. License number

054288

OCTOBER 30, 2010 9:54 p.m.

KELLIE LOOCK

				State of M						-		•	•
			1 - For State Registrar	Otato of W	ai yiai i	-	tificate			Wieritaring	Reg. N	DALA	31,272
	<b>5</b>	,	1. Decedent's Name (First, Middle, La	ast)						2. Date of De		4 0 1 0	3. Time of Death
	Physicia Medic		Kellie Lynn :				october 3					2010 Year	9:54 P. M
and a	Examin	er	4a. Facility Name (if not institution, give				4b. City, To	wn, or Loca	ation of Deat	h	4	c. County of Dea	:h
	F		Stella Maris Ho. 5. Social Security Number 6.		o (In une In	ast birthday)	Timonium  If Under 1 Year  If Under 24 Hrs.  8. Date of 8					Baltimor	
	Funeral Director			1 □ M 2 🔀 F	39	Yrs.			ours Min.	(Month, D	ay, Year)	Co	thplace (State or Foreign untry)
	, MC		Usual Residence of Decedent							IDec. 1	7,	1970  Mar	yrano
	ryland I-f sh	cţo	10a. State 10b. County	. 1		y, Town or Loc							10d. Inside City Limits
	or 288	Funeral Director	Maryland Worce:	ster	00	ean Ci	10f. Zip C	ode			10- 0	citizen of What Co	1  Yes 2 <b>XX</b> No
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	items er mi	Ē	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S		Vas Deceder	t of Hispani	ic Origin? (S	pecify Yes or No-		14. Race - Ame	rican Indian,
36	after o	ρ	1 Never Married 2 Married	1 Yes 2XX	No		r Yes, specify			o Rićan, etc.)		Black, White Specify: Whi	
8	e filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	3 Widowed 4 Divorced  15. Decedent's	Year or Dates.									
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pu	e filed tal Hyg ed oth event	To Be	17. Father's Name (First, Middle, Last)							me (First, Middle	, Maiden	Surname)	_
2	should be and Menta is marked raumatic e		Gary W. Loock  19a. Informant's Name/Relationship (	T 5		_				. Banks			
Maryland 21215-0036	1 and 2 should be file of Health and Mental I fitem 27 is marked o r other traumatic eve		Linda Loock / Mot	,, ,		1						or Town, State, Zij	and 21050
ē,	1 and 2 s of Health item 27 other tra		20a. Method of Disposition			ace of Dispos	sition (Name	of				ocation - City or	
e e	Page 1 ment of ant: If it ury or o		1 🔀 Burial 2 □ Cremation 3 ☐ 4 □ Donation 5 □ Other (Spec			emetery, crem Zion (				7. 3, 2010		,	
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signatur of Funeral Service Licer						acility	1 0 0	LBE	Air,	warviand
ш	90 <b>5 9</b> 9		Jun di Chaix	2			Newpo	rt Dr	ive Fo	rest Hi	II,	MArylan	ice Bel Air 1 21050
			23a. Part 1. Enter the disease, or con shock, or heart failure. List only	nplications that caused one cause on each line	the death	n. Do not ente	r the mode o	f dying, suc	ch as cardiad	or respiratory a	rrest,		Approximate Interval Between
-	Ph_sician/ Medical	ř	Immediate Cause (Final disease or condition resulting in death)	a. PELVIC									Onset and Death
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		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	consequ	ence of);							
	cuted nd ransit	Examiner	that initiated events	C									
	e be executed ysician and e burial-transit	cal E	resulting in death) Last	Due to (or as a	consequ	ence of):							
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89	eath certificate k attending phys I for use as the k	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	of pregnar	псу						23d. Date of del	iven
Box 6876	death certificate ne attending phy ed for use as the	Completed by Physician/Med	in the past 12 months? 1 ☐ Yes 2 🗶 No	1 Live Birth 4 Pregnant at	2 ∐ Fetal time of d	Ideath 3∟ eath 5□	Ectopic pre Other (spec	gnancy ify)				Month	Day Year
P.O. I		Phys	g Unknown	9 Unknown					-	1			
σ.	es tha igned be de	by	Part II. Other significant conditions	contributing to death bi	it not resu	alting in the ur	nderlying cat	ise given in l	Part I.			. /	the cause of death?
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ecc	rsician: The law rs certificate has be lirector, page 2 s	duo								24a. Was auto perfo		prior to death?	opsy findings available completion of cause of
<u>~</u>	an: Th tificate tor, pa	Be Co	25. Was case referred to medical	Γ				26 Place of	Death (Che	1 Yes	2 X N	lo 1 🗆 Yes	2 No
Z.	ysici lis cer direc	일	examiner? 1 \sum Yes 2 \boldsymbol{X} No	Hospital: 1 ☐ Inpatie	nt 2 🗆 I	ER/Outpatient		Other			dence (	6 X Other (Speci	fy) HOSPICE
1 of	or Attending Phys after death. Director: After this in by the funeral di		27. Manner of Death  1	28a. Date of injur (Month, Day,	y Year)	28b. Time of injury	28c.	Injury at work?		28d. Describe h			
ior	ttend death stor: A / the f	Certificate:	2 Accident Investigation 3 Suicide 6 Could not I	ne -			M	1 🗆 Yes	2 No				
Division of Vital Records,	al or A s after I Direct d in by		4 Homicide determined	28e. Place of Injurbuilding, etc.			et, ractory, o	nce		City or Tou		nd Number or Rur e)	al Route Number,
	Hospita 24 hours Funeral rted fillec	Medical	29a. Certifier 1 Certifying Phy	sician: To the best of r	ny knowle	edge, death o	ccured at the	time, date	and place, a	I nd due to the ca	use(s) aı	nd manner as sta	ted.
	To the Hospital or Attending Physician: The law requires that the with the 44 hours after death.  With the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	Me	only one) 3 X Certifying Nur	niner: On the basis of exese Practioner: To the b	amination sest of my	and/or investi knowledge, de	gation, in my eath occurred	opinion, dea I at the time,	th occurred a date and pla	at the time, date a ice, and due to th	and place e cause(	e, and due to the c s) and manner as	ause(s) and manner stated. stated.
	5 <b>5</b> ₹ 5		29b. Signature and title of certifier	on Chart	1		29c. Li	cense numb 7111A	9er	_	29d. Da	ite signed (Month	, Day, Year)
		ŀ	30. Name and address of person who	completed cause of de	ath (Item	 23a) (Type, Pr	rint)	177	110			111110	10
			JACKIE JONES, CE	NP 2300 D	ULAN	EY VAL		. TI	MONIUN	1, MD 21	093		
	Stat Registra	_	31. Date filed (Month, Day, Year)	32. Registra	's Signatu	ire							
DHM	IH 17 Rev 7/20		MUY 0 3 2010 /	Burn B.	190								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5state of Maryand 1 Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 1 Month Lillian Beatrice Liles 26 2010 9:30A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3719 Oakmont Ave. Baltimore 5. Social Security Number UNK 6. Sex . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Months Days Hours 06/23/1926 Min. Virginia Director 84 Usual Residence of Decedent fshow permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "---- any injury or other-t--10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1X Yes 2 No N/A MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3719 Oakmont Ave. 21215 U.S.A. 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates 3 XWidowed 4 ☐ Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Stephen WHite Estelle Shalton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delores Thompson(niece 5009 Chalgrove Ave., Baltimore, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 14 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) King Mem. Park 11/01/10 Owings Mills.MD 21. Signarure of Funeral Service Licenses 22 Name and Address of Facility
2740 N. Fulton Ave., Funeral Home 27217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, chock, or hear failure. List only one cause on each line.

Immediate Cause (Final nset and Death Physician/ disease or condition Medical resulting in death) ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Examir and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Month Day Year 1 ☐ Yes 2 ₽ 9 ☐ Unknown been signed by the a should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 💯 Completed Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 Yes 2 No Yes Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tes 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Division of Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending within 24 hours after death.

To the Funeral Director: Al
completed filled in by the fu Accident 1 Tyes 2 No Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical 29a. Certifier Certifying Physician: To the best of my ki owledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

ation and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Medical Examiner: On the basis of exami 3 = Certifying Nurse Practioner: To the be only one eath occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date Agned (Month, Day, Year) 26/2010 30. Name and address of State 0 3 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 30, 2010 1:30 Ам Barbara Ann Marlowe Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Stella Maris Timonium Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 7. Age (In vrs. last birthday 8. Date of Birth 1 □ M 2 🖵 F Days Hours Min June 25, 1928 Pennsylvania Director 456-36-1221 82 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Director 10a. State 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD Baltimore Timonium 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2525 Pot Spring Road 21093 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. by 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Social Worker State of Maryland Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Lain |Helen Ekelman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marty Fleming 2525 Pot Spring Road K507; Timonium, MD 21093 niece perr it. Page 1 and 2
Department of Healt
Important: If item 2
any injury or other other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 4 Donat on 5 Other (Specify) <u>ılaney Valley Mem Garden</u>s 11/3/2010 Timonium, MD Fundral Service Licenses 21. Signature of 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Towson, MD 21204 Inc. 23a. Part 1. Inter the disease, or complicati that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one of e on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ UTERINE CANCER Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 🗶 No
9 ☐ Unknown Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy autopsy performed? Yes 2 X No 2 🗌 No 1 Tyes completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours after death. work? 1 Yes 2 No 1 🗶 Natural injury 5 Pending 2 Accident
3 Suicide Investigation Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Tentifying Number Practioner: To the best of my in overlage, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check 29b. Signature and fitle of o 29d. Date signed (Month, Day, Year) 2010 of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

a.m.

1:30

OCTOBER

2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Florence 12:45PM 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Towson Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Days Hours 1 🗆 M 2 🖵 F Months June 11ay, 1927 094-20-5896 New York Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Towson 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 28 Allegheny Avenue 21204 U.S.A. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 🗙 No If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 Widowed 4 X Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Postal Service Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James McManus, Sr. Florence Keane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles McManus-nephew 304 Gailridge Rd., Timonium, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, St. Raymond's 20c. Location - City or Town, State 1 📜 Burial 2 □ Cremation 3 □ Removal from State 11/6/10 Bronx, NY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility William G. Dau Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardlac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Liver resulting in death) Due to (or as a consequence of) Sequentially list conditions.

Ph sician/ Medical Examiner

Physician/

Medical

Director

Funeral

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Completed

Be

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**Examiner** 

**Funeral** 

**Director** 

within 72 hours after death with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at

al Hygiene.

Ith and Mental F 27 is marked or traumatic ever

Department of Health and Menta Important: If item 27 is marked any injury or other traumation once.

Baltimore, Maryland 21215-0036

Examiner Physician/Medical ģ Completed Be မ Certificate:

the Hospital or Attending Physician; The law requires that the death certificate be executed

nas

Director: /

Medical

29a, Certifier

(Check

29b. Signature and title of certifier

anp

Division of Vital Records, P.O. Box 68760

ause. Enter Underlying ause (Cisease or injury nat initiated events esulting in death) Last	c. Due to (or as a consequence of):					
	d					-
FEMALE: bb. Was decedent pregnant in the past 12 months? 1  Yes  No 9 Unknown	23c. If yes, outcome of pregnancy  1  Live Birth 2  Fetal death 3  Ectopic pregnancy  4  Pregnant at time of death 5  Other (specify)			23d. Date of de Month	elivery Day	Year
art II. Other significant conditions co	ontributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco u	se contribute to	o the cause o	f death?
		_	1 🗌 Yes 2	□ No 3□F	Probably 4	Unknown
		_	24a. Was an autopsy performed?	death?	utopsy finding completion o	
. Was case referred to medical	26. Place of Death (C/	heck only				
examiner? 1  Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing	g Home	5 Residence 6	Other (Spec	city In pert	cent Ha
. Manner of Death  1	28a. Date of injury (Month, Day, Year)  28b. Time of injury at work?  M 1 ☐ Yes 2 ☐ No	28d.	Describe how injury			
4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		Location (Street and City or Town, State)		ıral Route Nu	nber,

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated

altimore,

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Selectifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

R125808

DHMH 17 Rev 7/2009

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) And Lewis Villanuer

4105

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>010</u> NOV Physician/ 8:25A EVELYN ANNA MELVILLE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 9427 Dawn Drive Baltimore County 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** ABTTT Pay 2 6 ar) 1914 1 🗆 M 2 💢 F Months Hours Maryland 96 212-28-4906 Director Usual Residence of Decedent 3a or 28a-f show the notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 Yes 2 No Baltimore County Maryland Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 23a Funeral 21236 USA 9427 Dawn Drive traumatic event, the Medical Examiner must items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes XX No
If Yes, Give
Year or Dates. Black, White, etc. 9 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: White "natural". 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 I h and Mental Hygiene. 7 is marked other than "n College (1-4 or 5+) N/A Elementary/Seconday (0-12) Belmar Bakerv Salesperson 8th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) t. Page 1 and 2 should be file tment of Health and Mental tant: If item 27 is marked o Elizabeth J. Holzscheur Gottlieb Scheerer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Constance E. Iacarino (Daughter) 9427 Dawn Drive Baltimore, Md. 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any Injury or o once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore Cemetery 11-4-2010 Baltimore City, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Lassann Funeral Home 7401 Belair Rd. Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on ach line. Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ hours Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to for as a consequence of, ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 F FEMALE: outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: The law requires that the death Month Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No this certificate 24 hours after death.
Funeral Director: After this certificated filled in by the funeral director, I 25. Was case referr 26. Place of Death (Check only one) Be examiner? Other: 2 1 Yes 2 - No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of Certificate: 27. Manner of Death 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier within 24 hou

To the Funer

completed file 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed cause of death 10

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

			Please Type o Amend \$125 per M \$165 State	r Print in D g909 of Maryla	Black	Indelible In 10 TT partment of	<b>k. Ensure</b> Health and	All Copie Mental Hy	es Are	Legible	
			1 - State Registrar	,		ertificate of		-	Reg. No.	ZUIL	34277
	Physici Med		Decedent's Name (First, Middle, Last)  John  M	ills				2. Date of D	<sub>eath</sub> ber Day	30 29, Year	3. Time of Death 10:20A M
	Exami		4a. Facility Name (if not institution, give street and nu	or Location of Dea	ith	4c. 0	County of Dea				
10	Funera	7	518 Saint Francis  5. Social Security Number 6. Sex	s. 8. Date of Bi	irth	Balti Balti	LMOTE thplace (State or Foreign				
	Director		5. Social Security Number 249-07-8990  Usual Residence of Decedent	7. Age (In yrs 90	Yrs.	Months Days	Hours Mir	02 - 02	ay, Year) 2 - 20	Co	SC SC
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ctor	10a. State 10b. County	10c. C	City, Town or I		-	-			10d. Inside City Limits 1 ☐ Yes ※ ※ No
	the Ma or 28a e notif	Dire	MD Baltimore  10e. Street and Number		T	OWSON 10f. Zip Code			10g. Citiz	en of What Co	
	h with 1s 23a nust b	Funeral Director	518 Saint Francis R	oad		212	86			USA	
	or item	by Fu	Armed F	cedent Ever in U orces? 2 <b>X</b> No	J.S. 13	. Was Decedent of H If Yes, specify Cub	lispanic Origin? (S an, Mexican, Pue	Specify Yes or No rto Rican, etc.)	- 14	4. Race - Ame Black, Whit	erican Indian, e, etc.African
200	ural",		3 Widowed 4 Divorced If Yes, G	ive		1 ☐ Yes 2 🖾 No	Specify:		S	Ame	rican
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Mil	within giene. er tha		/th Grade NA	1-4 or 5+)		penter	1				tion Co.
7	ntal Hy ed oth	To Be	17. Father's Name (First, Middle, Last)					ame (First, Middle		,	
John	nould b		Mannie Mills  19a. Informant's Name/Relationship (Type, Print)		19b. Ma	ling Address (Street	Addie	rural Route Numb		evens	on <sub>p Code)</sub> 21286
	nd 2 sh ealth a m 27 is		Jessie Mae Mills-Wi	fe		3 Saint					
Dec:	ige 1 a nt of H		20a. Method of Disposition  ¡XXBurial 2 ☐ Cremation 3 ☐ Removal from	n State	cemetery, cr	position (Name of ematory or other pla		Date		ation - City or	
	mit. Pa bartme bortani r injury		4 ☐ Donation 5 ☐ Other (Specify)  21. Signalure of Funeral Servige Licensee	K		dson Mem		-08-10 Wylie			anch, SC ome P.A.
ă	permi Depar Impo any ir		Junela Ge	hes		638 N. (	Gilmor	Street	Balt	imore	, MD 21217
	Physician/	8 9	23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause of elimendiate Cause (Final disease or condition	caused the dea	ath. Do not e	nter the mode of dyir ve 서と	ng, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death 5 YEARS
	Medical Examiner		resulting in death)  Due to	(or as a conse	nce of):	· .	A	di	A		10 years
		iner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying	(or as a conse	quence oi).	y an	1020	æ	ensa		10 1007
	executed an and ial-transi	Examiner	Cause (Disease or linjury that initiated events c.	(or as a conse	quence of:						
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Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medical	in the past 12 months?	itcome of pregr Birth 2  Fe gnant at time of known	tal death 3	☐ Ectopic pregnand ☐ Other (specify) ☐	су		23	3d. Date of de Month	livery Day Year
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_	To the within To the comp	-	29b. Signature and title of certifier	ava,	M.D	29c. Licens				signed (Monti	
$G_{i}$	7		30. Name and address of person who completed cau	se of death (Ite		Print) P	t- + 11	LER	a little	` `	1021218
1	Sta	te	ovarec annaver	Registrar's Signa	ature	rd 3	Thee T	(040, 0	or allan		0 -1,-(8
V	Registr	ar	NOV 0 3 2010 Sensus	1. April	well						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 13 2010 Physician/ OCTOBER MITCHELL THERESA 9:05 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY ROCKVILLE CASEY HOUSE If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 1 □ M 2 🕱 F Months Days Hours Min (Month, Day, Year) MAY 25 1937 WASHINGTON, DC Director 579-50-6075 73 Usual Residence of Decedent 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f shov Examiner must be notified at 10a, State 10c. City. Town or Location be filed within 72 hours after death with the Maryland Director 1 Yes 2 No HYATTSVILLE PRINCE GEORGE'S MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA E CHESAPEAKE STREET 20785 7100 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 X No
If Yes, Give Black, White, etc. 1 Never Married 2 XMarried Completed by Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2X No Specify "natural", 3 Widowed 4 Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important. If iten 27 is marked other the any injury or other traumatic event, the Ionce. PRIVATE 9TH HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ REBECCA S. STROTHERS WILLIAM L. MUSGROVE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20785 19a. Informant's Name/Relationship (Type, Print) 7100 E. CHESAPEAKE STREET HYATTSVILLE, MARYLAND MITCHELL/HUSBAND JAMES 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State MD VETERANS CEMETERY | 11/4/2010 CHELTENHAM, MARYLAND 4 Donation 5 Other (Specify) 22. Name and Address of Facility J. B.JENKINS FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition OVARIAN CANCEL Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Year Month Day Pregnant at time of death 9 Unknown the 8 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😾 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2: autopsy performed Yes 2 X No 2 X No Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? 2 X No Hospital Other: HOSPICE 1 🗌 Yes 4 Nursing Home 5 Residence 6 Nother (Specify) မြ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of nours after death. neral Director: After the filled in by the funeral 28c. Injury at 28d. Describe how injury occurred Certificate: injury X Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital within 24 hours a To the Funeral C Medical etrifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) OCTOBER 14, 2010 RN43201 CRMP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) c))! MUNCASTER MILL ROAD ROCKVILLE, MARYLAND 20855 DRBORAH MILLER

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DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October John Gazzo Martinez 2010 3:30 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hospice Casey House Rockville Montgomery Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Xe November 9 **Funeral** 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours 1 🛛 M 2 🗆 F 83 1926 Louisiana 031-12-4824 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Bethesda 1 Yes 2 X No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6705 Wilson Lane 20817 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Q.Z. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1946 Black, White, etc. 1 Never Married 2 X Married Completed by Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 1973 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Manager Logistics Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ James Robert Fiddis Martinez Emma Jeanne Gazzo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6705 Wilson Lane, Bethesda, Maryland 20817 Elinor Noble Martinez / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State January 31, Arlington National Cemetery 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington, Virginia 2011 Signature of Funer, Service Licenses Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. selettakon M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Lewy Body Dementia disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) Cause (Disease or linjury that initiated events igned by the attending physician and be detached for use as the burial-trans Due to (or as a consequence of): resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Dav Pregnant at time of death been signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed?

1 Yes 2 X No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital 1 🗆 Yes 2 🗓 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident ☐ Suicide Investigation To the Funeral Director: completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signati 29c. License number 29d. Date signed (Month, Day, Year) 40+1 R143201 October 28, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Debrah Miller, CRNP 6001 Muncaster Mill Road, Rockville, Maryland 20855

Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day,

32. Registrate Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34280 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Robert L. Myers 2010 10:55P M October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A **Examiner** Loch Raven Baltimore Rehabilitation VA Center Baltimore 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country)
Manchester, Marylan (Month, Day, Year)

March 22,1924 Days Hours 220-16-1301 86 Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Parkville Baltimore Maryland 1 Yes 2XXNo 10e. Street and Number Ь 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a on the Medical Examiner must be Funeral 21234 9525 Ridgely Avenue United States Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Armed Forces?

1 1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXXNo Specify: Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other than Owner Taxi Driver Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen Lippy I and 2 should be fill Health and Mental ည John T. Myers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Iown, State, Zip Code) 21 9525 Ridgely Avenue Parkviile, Maryland (Wife) Antonietta C. Myers 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a Department of H 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place)

Evans Funeral Chapel oct. 31,2010 Forest Hill, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services-Parkville 8800 Harford Road Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or learn failure. Let only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ ances disease or condition Medical resulting in death) a consequence of) **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Due to for as a consequence of Examin -transit Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month ed by the 9 Unknown P.O. signed I Part II. Oth<mark>er significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? Yes 2 N death? certificate 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 No 1 Yes Other: ၉ 4 Nursing Home 5 Residence 6 YOther (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 1 Natural 5 Pending work Accident
Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

## 10-08199

Charles Thomas Morgan

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		Registrar		Cert	ificate of	f Death			R	eg. No.	
Physic		1. Decedent's Name (First, Midd						2	2. Date of Dea Month	ith Day Yea	3. Time of Death
Medical Exam	ine	CHARLES THOM	AS MORGAN						October 2		2012 hrs
		4a. Facility Name (if not institution		er)		4b. City, Town,	or Location	of Death		4c. County o	
		6 Wood Stream Cour	t, Apt. 9			Owings M	ills			Baltimore	e County
Funeral		5. Social Security Number	6. Sex 7. /	Age (In yrs, las	st birthday)	If Under 1 Ye			8. Date of Bi	rth (MM/DD/YYYY)	Birthplace (State or
Director		216-11-2182	1XM 2_F	0.4	Yrs	Months Da	ays Hour	rs Min.	12-25	5-1985	Foreign Country)MARYLAND
		Usual Residence of Decedent		24							//IIIIIII
any		10a. State 10b. County		10c. City, T	own or Locat	ion					10d. Inside City Limits
* *	١.	MD. BALTI	IMORE	NO N	INGS M	ITLLS					1 Yes 2 No
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hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once	=	6 WOODSTREAM				2111				USA	
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or it	큔		1 Yes	2 X No					, ,		
s afte ral",	۾		orced If Yes, Give Year or Dates:			Yes 2 X N				Specify: I	
5-0036 led within 72 hours tygiene. other than "natur the Medical Exami	9	15. Decedent's Education (Spe				t's Usual Occup ost of working lif				16b. Kind of Bus	iness/Industry
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21215-0036 nuld be filed within 7 Mental Hygiene. marked other than	Be	DOUGLAS H. MC					MA	ARY A.	KING		
Shoul and M	2	19a. Informant's Name/Relations									, State, Zip Code)
imore, MD 2 Pages 1 and 2 shou ment of Health and N tant: If item 27 is n or other traumatic		INDIA S. MORG	GAN(WIFE)		6 WOO	DSTREAM	CT A	APT 9	OWINGS	MILLS,	MARYLAND 21117
ore, M es 1 and 2 of Health If item 2		20a. Method of Disposition  1 X Burial 2 Cremation	3 Removal from 5	20b. Pla	ace of Disposi ematory or oth	ition (Name of coner place)	emetery,		Date	20c. Location - (	City or Town, State
mc Page sent c		4 Dorgation 5 Other So			MEMOR	IAL PAR	K	11-5-	2010	RAT.TTMOR	RE, MARYLAND
Baltimore, permit. Pages 1 as Department of He Important: If ite injury or other tr		21. Signature of Funeral Service		N D. H	IBNERN	ame and Addres	ss of Facilit	PHTI.I.	TPS FI	NERAL HO	OMÉ, P.A.
E P P E		Toatt	' All	3_	172	1-27 N.	MONR	ROE ST	'. BAT.T	TMORE M	ARÝLAND 21217
Physician		23a. Part I. Enter the disease, or	complications that cause	d the death. D	o not enter th	e mode of dying	, such as o	cardiac or re	espiratory arre	est, shock, or hear	rt Approximate Interval
/Medical		failure. List only one cause Introlediate Cause (Final disease		r oungh	not Wor	ınd of h	nead				Between Onset and Death
Examiner		or condition resulting in death)	Due to (or as a con								-
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8760, uificate be ng physic as the bun	Š	IF FEMALE: 23b. Was decedent pregnant in th	23c. If yes, outco			al death 3	Ectonic	c pregnancy	,	23d. Date of d Month	lelivery Day Year
K 6.	cia	past 12 months?	4 Pregnant a	at time of death	•	er (Specify)		o programo	,	I Month	Day real
Box e death c the atten ed for us	Physicia	1 Yes 2 No 9 Unk	9 Unknown		0						
<b>ords, P.O. Box 6</b> w requires that the death cert is been signed by the attendition should be detached for use a		Part II. Other significant conditi	ons contributing to dea	th but not resu	ulting in the ur	nderlying cause	given in Pa	art I.	23e. Did to	bacco use contrib	ute to the cause of death?
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COI law has l	ldu								autops perfor		or to completion of cause of ath?
tal Reco	ပ္ပ								1 Yes 2	2 No 1	✓ Yes 2 No
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Be	25. Was case referred to medical examiner?	Hoonital:		_		Lau.	(Check only			
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Vision or A after Dire	ij		not be			, factory, office I	building, et	tc. 28	f. Location (S	treet and Number	or Rural Route Number, City
Spital fours	Certification:	4 Homicide	mined (Specify)	res	sidence	<del></del>		O	wings l	Mills, M	Stream Ct
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Division  To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical		niner: On the basis of exa and manner stated		or investigation	on, in my opinior	n, death oc	curred at th	e time, date a	and place, and due	to the cause(s)
	Σ	29b. Signature and title of certifier				29c. Licens				29d. Date signed	(Month, Day, Year)
		(andle	Hason	65		O.C.	M.E.			October 27,	2010
	1	30. Name and address of person	who completed cause of	death (Item 23	Ba)						
		Carol Allan, MD Ass	istant Medical Exa	miner 1	11 Penn S	treet, Baltim	ore, MD	21201			
	ate	31. Date filed (Month, Day, Year)	0010	ar's Signature	6 km	cked		_			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19b Per FH G909/10/03/10 IH. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Betty Mae Noyes Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore Union Memorial Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Feb. 14, 1931** 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 🗆 M 2 🗶 F Months Hours 79 Baltimore, MD. 220-24-2782 **Director** Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Completed by Funeral Director Fallston Harford Co. Maryland 1 Yes 2X No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21047 2202 Hampshire Drive United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates White 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Cashier **Grocery Store** 10 N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ! ٩ Catherine Herold Raymond Anderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2418 Pleaseantville Road Fallston, MD. 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trau once. Fallston, MD. 21047 Mrs. Terri C. Quingert (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place)

Evens Funeral Chapel and 20a. Method of Disposition 20c. Location - City or Town, State (Harford Co.) 1 Burial 2 🔀 Cremation 3 🗆 Removal from State Tresday 4 Donation 5 Other (Specify) Nov. 02, 2010 Forest Hill, Maryland Cremetion Services Inc. 22. Name and Address of Facility

Peaceful Alternatives Funeral & Cremation Center, P.A. of Funeral Service Licensee Jeffrey L. Gair, Sr. /~Lic.#M00677 2325 York Road Timonium, Maryland 23a. Part 1. Enter the lisease, Part 1. Enter the risease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear of dilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ 46 Medical Examiner (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Year Day signed by the a 1 Yes 2 L 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contrio e to the cause of death? Completed by 1 Tes 2 o 3 Probably 4 Unknown Division of Vital Records, To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed? Yes 2 No 2 ANO 1 🗌 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) ၉ 1 Inpatient 2 🗗 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred of or Attending Parter death.

I Director: After t 1 L Hatural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 🖟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and fittle 31. Date filed (Month, Day, Year) State 0 3 2010

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month David Winfield Oler 2010 8:14 P.M October Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Dove House Westminster 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth **Funeral** (Month, Day, Year) 1**XX**M 2 □ F Days Min. Director 217-36-4895 71 Yrs. Usual Residence of Decedent 28a-f show er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes XX No Maryland Baltimore Upperco 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? United States of America Funeral 15751 Dover Road 21155 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 MX Married ò Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2XX No Specify. Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working should be filed within 72 h and Mental Hygiene. life. DO NOT use retired) Social Security Elementary/Seconday (0-12) College (1-4 or 5+) 12th Administration Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ပ္ Richard Winfield Oler Eleanor M. Becker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is LoisAnn Furgess-Oler (Wife) 15751 Dover Road, Upperco, Maryland 21155 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Nov. 4, 20c. Location - City or Town, State Page 1 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State injury or 4 Donation 5 Other (Specify) Riverview Cemetery 2010 Trenton, New Jersey ignature of Funer Serv Licerpe 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. any Charmil Drive, Manchester, Maryland 21102 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Due to (or as a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that the death certificate be executed Exam and that initiated events Due to (or as a resulting in death) Last consequence of burial attending physician for use as the buria Physician/Medical Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Dav Year 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death Yes 2 No signed by the a d be detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 1 🗌 Yes 3 Probably 4 Unknown s been signated by should be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 s autopsy Hospital or Attending Physic an: of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 Yes からては မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence this within 24 hours after death.

To the Funeral Director; After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury Division 1 Yes 2 No Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State, Medical 29a. Certifier Certifying Physician: To the best of pay knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Under the cause of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year) 2010 empleted cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 34284 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 30 3. Time of Death Month Ye ar **Physician** 2 - 20 AM eace vorman Hlexande October 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St Agnes Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. jast birthday) **Funeral** 220-64-8166 Months Days Hours 1 M M 2 □ F Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location d 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene.
77 Is marked other than "natural", or items 23a or 28a-f show traumatic event, it a Medical Examinant met be notified at **Funeral Director** 1 XYes 2 No timore 10g. Citizen of What Country 10e. Street and Numb 10f. Zip Code 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 2 X No Maryland 21215-0036 1 ☐Yes 2 No If Yes, Give Year or Dates: Specify. <u>ک</u> 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. PO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) achinist 18 Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) orman ဂ Informant's Name/Relationship (Type. Pages 1 and 2 s ment of Health ar Health a ale veronica Item 27 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory, or other place) 20a. Method of Disposition permit. Pages
Department of
Important: If It
any Injury or o 1⊠Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) oudon 22. Name and Address of Facility Vaughn, C. Greene Funeral 5151 Baltmore National re of Funeral Service Lipe 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ntracoanial day disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Gertensio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed attending physician and for use as the burial-tra Due to (or as a consequence of): 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? page 2 certificate 2 🗆 No Vital 1 ☐ Yes 1 ☐ Yes Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation Hospital or Attending Division 1 Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No death. hours after death uneral Director: 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide within 24 hours a Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only To the 1 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD Octobe 30 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St. Africa Hisupama D. Mitikiri MD 900 Caton Arenue Hospital itimore, MD 21229 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 19:51 PM JOSEPHINE PECORA OCTOBER 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Dec. 6, 1920 9. Birthplace (State or Foreign Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) Hours Days 1 ☐ M 2X☐ F Maryland 89 Director 213-16-4048 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examinar must have a trained. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2XXNo Dunda1k MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 305 Wise Ave. 21222 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married ☐ Yes Yes, Give 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Baltimore County Elementary/Seconday (0-12) College (1-4 or 5+) 12 Years Secretary Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mary Przybyl Joseph Socha 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 301 Wise Ave. Dundalk, Yaryland 21222 Nick Pecora (Nephew) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Loly Rosary Cemetery 20c. Location - City or Town, State Date 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 11 /2/2010 Baltimore, LD 4 ☐ Donation 5 ☐ Other (Specify) 21. Si ature 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. neral Se Wise Ave. Dundalk. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ph\_sician/ BOWEL PERFORATION 1 DAY Medical Due to (or as a consequence of) **Examiner** 2 weeks CONSTIPATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated second Examine Due to (or as a consequence of) ttending physician and or use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death To the Hospital or Attending Physician: The law requires that the dewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 2 🗌 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 X No Other: ည 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death icate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accider 3 Suicide 5 Pending 2 🗌 No Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4  $\square$  Homicide City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) RES-000 OCTOBER 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WILLIAM BURNS M.D. 4940 FA

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

NOV O

9

32. Registra s Signature

4940 EASTERN AVENUE

BALTIMORE MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 2010 10:12 PM Physician/ Samue1 Poulos Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Baltimore Towson Gilchrist 8. Date of Birth Oct., 27, Year 932 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Months Hours 213-30-3058 1 ★ M 2 🗆 F Pernsylvania 78 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State by Funeral Director Maryland Cockeysville 1 Yes 2 No Baltimore 10f, Zip Code 10g. Citizen of What Country? 10e, Street and Numbe 21030 U.S.A. 10861 Sandringham Road 12. Was Decedent Ever in U.S. Armed Forces?
1 X Yes 2 No If Yes, Give 1951–55 Year or Dates. Page 1 and 2 should be filed within 72 hours after death unent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Ith and Mental Hygiene.

27 is marked other than "r
traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Welding Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Thomakos Anna Daniel Samuel Poulos 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a, Informant's Name/Relationship (Type, Print) 21093 Timonium, Maryland Drive 753 Leister Dan Poulos / Son Department of Healtl Important; If item 2 any injury or other tonce. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 K Burial 2 Cremation 3 Removal from State Nov. 3 2010 Woodlawn, Maryland Greek Orthodox Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Sa 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Plly ician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate bauss. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ atter for u in the past 12 months? Day Year 1 Yes 2 No signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an death? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: Hospital: 10 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No After thi funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pendina 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours at er dea To the Funeral Director: completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Number Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29d. Datersigned (Month, Day, Year) 29b. Signature and title of 30 1040 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10+1 21200 STREET CHARLES KUMA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State	of Maryla		artment of I		and M	ental Hy	giene	010	34287
			Registrar  1. Decedent's Name (First, Middle,	( act)		Cei	tificate of l	Jean		Reg. No.			
	Physicia	an/	Dorotha	E.	P	eregoy			- 1	Month	Day	Year	3. Time of Death
	Medic		4a. Facility Name (if not institution,	aive street and nu			4h City Town o	r Location o	of Dooth	Octobe			
	Examir	ier	Kensington Nurs				4b. City, Town, or Location of Death  Kensington					ounty of Dea lontgo	
	Funeral			6. Sex		s. last birthday)	If Under 1 Year			8. Date of Bir	h	9. Bi	rthplace (State or Foreign
	Director		188-18-4776	1 □ M 2 🛣 F	88	Yrs.	Months Days	Hours	Min.	(Month, Da	y, Year)	2 00	ountry) Ohio
	3		Usual Residence of Decedent							TPITI 2	.0,172		Unito
	land f sho	호	10a. State 10b. County		10c.	City, Town or Lo							10d. Inside City Limits
	Mary 28a-1 otifie	Director	MD Montg	omery			Silver S	pring					1 ☐ Yes 2 🔀 No
	n the	읕	10e. Street and Number	- n11	#1100		10f. Zip Code				0	n of What C	*
	I be filed within 72 hours after death with the Maryland fental Hygiene. rked other than "natural", or items 23a or 28a-f show fice event, the Medical Examiner must be notified at	Funeral	1121 University		#1109			.0902			Uni	ted S	tates
	deat r iten ner r		11. Marital Status	U.S. 13. \	Was Decedent of H f Yes, specify Cuba	lispanic Orig an, Mexican,	gin? (Spec , Puerto F	cify Yes or No- Rican, etc.)	14	. Race - Ame Black, Whit	erican Indian, te. etc		
36	after I", ol xami	d by	1 ☐ Never Married 2 ☐ Marrie 3 🛛 Widowed 4 ☐ Divorced		I ☐ Yes 2 🔀 No	Specify:	Sp		hite				
ခု	ours atura cal E	Completed	15, Decedent	16a Docor	dent's Usual Occup	ation			405 165 1	, ,	to book		
5	72 h In "n Medi	Ig I	(Specify only highes	(Give	kind of work done ( O NOT use retired)	during most	of workin	g	160. Kina	of Business	s industry		
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Ö	filed wit al Hygiei d other i	Be	17. Father's Name (First, Middle, La	st)				18. Mothe	er's Name	(First, Middle,	Maiden Sur	name)	
Maryland 21215-0036	be f lenta rked tic ev	욘	Har1ey		Gardne:	r		Mar:	ie			Bates	
ar <sub>Z</sub>	2 should be Ith and Ment 27 is marker • traumatic e		19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailir	ng Address (Street	and Numbei	r or Rurai	Route Numbe	r, City or To	wn, State, Z	ip Code)
Ξ	d 2 sl alth a 27 is rrtra		Alan Peregoy /	Son		1604	Tilton	Dr.,	Silve	er Spri	ng, M	D 20	902
ē,	1 and 2 of Healt item 2 other 1		20a. Method of Disposition	_	201	o. Place of Dispo			D	ate	20c. Loca	ition - City o	r Town, State
Ë	Page nent c nt: If ry or		1 ☐ Burial 2 XXCremation 3 4 ☐ Donation 5 ☐ Other (Sp		n State C1		natory or other plac ce Cremat		11/2	/2010	Вe	ltsvi	11e, MD
Baltimore,	permit. Page 1: Department of I Important: If it any injury or of		21. Signature of Funeral Service Line		M0038								
ñ	an II De		Structoro	Kuman	•	,	Name and Addre Rapp Fune 933 Gist	ra⊥ aı Ave.,	nd Ci Silv	rematio 7er Spr	n Ser	vices MD	20910
			23a. Part 1. Enter the disease, or o	complications that	caused the de								Approximate
	Physician/		shock, or heart failure. List on Immediate Cause (Final			. /	Misoria	-1.	2	. 10 -			Interval Between Onset and Death
	Medical		disease or condition resulting in death)	Due to	(or as a cons	equence of):	PHOCYT	16	LEC	JKEI	TIA		
	Examiner			(50.50)	(= =								
		ner	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a conse	equence of):							
	ansit	Examiner	cause, Enter Underlying Cause (Disease or iinjury										
	executed ian and irial-transit	EX	that initiated events resulting in death) Last	Due to	(or as a conse	equence of):							
09	cate be executed physician and s the burial-transit	dical		d									
20	certificate be nding physicii use as the bu	10	IF FEMALE:										L
Box 68	n cert tendii r use	Physician/M	23b. Was decedent pregnant	23c. If yes, ou			Ectopic pregnanc	CV			230	d. Date of de	elivery
P P	deatl ne atl ed fo	sici	in the past 12 months?  1  Yes 2 No		gnant at time o		Other (specify)					Month	Day Year
o	t the by the	Phy	9 Unknown			una di na in ila		uan in Davi I		1			
л. О	s tha igned be de	by	Part II. Other significant condition	s contributing to t	death but not	resulting in the u	ndenying cause gr	ven in Pari I.					o the cause of death?
<u>g</u>	equire sen s ould	Completed								1	Yes 2 🔁	No 3 🗆 F	Probably 4 🗆 Unknown
<del>ဂ</del>	aw re as be									24a. Was autor	sy	prior to	utopsy findings available completion of cause of
Å T	The late h	S								perfo 1 ☐ Yes	rmed? 2 🔀 No	death?	s 2 ANo
<u>a</u>	sian: ertific ctor,	Be (	25. Was case referred to medical examiner?					ace of Deatl	h (Check	only one)			
5	hysic his o	유	1 🗌 Yes 2 🗖 No			☐ ER/Outpatier	nt 3 □ DOA Oth	er: 4 Nui	rsing Hon	ne 5 🗆 Resid	lence 6	Other (Spe	cify)
0	ing P	ate:	27. Manner of Death 1 ₩ Natural 5 □ Pending	28a. Date (Mor	e of injury hth, Day, Year)	28b. Time of injury	28c. Injur work	?		8d. Describe h	ow injury o	curred	
0	tend leath tor: A the f	iţic	2 Accident Investiga 3 Suicide 6 Could no	ation of he		1		Yes 2	_				
Division of Vital Records,	or At after of Direct in by	Certificate:	4  Homicide determin	28e. Place	e of Injury - At ling, etc. <i>(</i> S <i>p</i> ed		eet, factory, office		2	8f. Location (S City or Tow		umber or Ru	ural Route Number,
29a. Certifier 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
	Hos 24 h 24 h Fun eted	Medical	(Check 2 Medical Ex	aminer: On the ba	sis of examina	tion and/or invest	igation, in my opinio	on, death occ	curred at t	he time, date a	nd place, an	nd due to the	cause(s) and manner stated.
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	2	only one) 3 ☐ Certifying 1 29b. Signature and title of certifier	Nurse Practioner:	TO THE DEST OF	my knowledge, (	29c. License		and place				th, Day, Year)
	- > - 0		1 Tu	Beno	, mn		Doc	577	120		11	1,1	10
	7		30, Name and address of person w	,		em 23a) (Tvne. F						<del>' '  </del>	. •
			Truong Bao, M				er Dr., #	201, 1	Rocky	ville,	MD 2	0850	
	Stat	te	31. Date filed (Month, Day, Year)			- 4							
	Registra		NOV 0 3 2010	Cknown	1. 19	anke							

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Certification: To this

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Maryland 21215-0020

Baltimore,

Completed by Be

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Director: After this d in by the funeral within 24 hours eft To the Funeral Di completely filled in

Division of Vital Records, P.O. Box 68760,

State Registrar

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 212No 1 Yes 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 ☐ Nursing Home 5 🕅 Residence 6 ☐ Other (Specify) 1XYes 2□ No 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1'Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number

29d. Date signed (Month. Dav. Year)

30. Name end address of person who completed cause of death (Item 23e) (Type, Print)

M: (: + elloi MD Trumble

3. Registrar's Signature 31. Date filed (Month, Day, Year) NOV 0 3 2010

Marke

DHMH 16 Rev 6/95

10-08220

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Jacqueline Palm		1- For State Registrar	Sta	ite of Maryla			nt of Hea		d Men	tal Hyg		leg. No.	201	0	342	289
Physicia Medical Examir	n/	1. Decedent's Name		,Last) ine Palmer				_			Date of Dea Month October 2	ath Day	Year		3. Time of Dec 1950 hrs	
		4a. Facility Name (if 7204 Valley			mber)			, Town, or esville	Location o	of Death			County of Baltimore		ity	
Funeral Director		5. Social Security Nu		5. Sex	7. Age (In yrs.	last birtho		nder 1 Yea	_		8. Date of Bi		1	9. Birth Foreign Cour		or
any		Usual Residence of I 10a, State 1				y, Town or	Location				10-21	-1.0.		- 1	10d. Inside Ci	-
aryland 8a-f show at once,	Director	MD 10e. Street and Num		timore		Pik	esville 10f. 2	Zip Code			[1	0g. Citi:	zen of Wha		1 Yes 2	2 X No
vith the M s 23a or 2 e notified		7204 Valley	Countr		T2 edent Ever in t	U.S. 1	3. Was Dece	21208	spanic Orio	in? (Spec	ifv Yes or No	)- T	USA	America	an Indian, Bla	ck.
ifter death v	by Funeral	1 Never Married 3 Widowed			orces?		If Yes, spe	ecify Cubar	n, Mexican,				White,	etc.	ican-Ame	
6 n 72 hours e an "nature ical Exami	Completed b	15. Decedent's Edu Elementary/Secon		College (1		du	cedent's Usuring most of v						Kind of Busi		dustry	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Montal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Be Comp	17. Father's Name (F Jeffers Z. I		•		J (1)	erical			•	irst, Middle, lackwel	Maiden	amarket Surname)	ing		
MD 21 2 should I h and Mer 27 is mar 1 matic ev	्रा	19a. Informant's Nam Ella M. Palm					Mailing Addre						-			
Baltimore, I bermit. Pages I and Department of Healt Important: If item		20a. Method of Dispo 1 Burial 2 \( \) 4 Donation 5	Cremation	3 Removal fro	om State	crematory	Disposition (No or other place	ce)		11 <b>-</b> 2-2	oate 010		Location - C			
Balti permit. Departm Imports		21. Signature of Fund			Cell	(v)	22. Name at 9200 L.			-				of	Balto. (	.o.
Physician IV.c.dicul xaminer		23a. Part I) Enter the failure. List only Immediate Cause (F or condition resulting	one cause o		∦ Thromboer	mbolism		e of dying,	such as ca	ardiac or re	spiratory arr	est, sho	ock, or heart		Approximate Between On Deatt	set and
	Examiner	Sequentially list conditions if any, leading to immicause. Enter Underl	nediate lying Cause	b. Due to (or as a	consequence	of):										
), be executed cian and urial - transit	I Exan	(Disease or injury the events resulting in de		Due to (or as a d.	consequence	of):										
60, tte be exe hysician a	Medical	UNPENDED  IF FEMALE:		AMENDED	outcome of pre	onancy						230	d. Date of de	elivery		
Division of Vital Records, P.O. Box 68760  Division of Vital Records, P.O. Box 68760 ra for Attending Physician: The law requires that the death certificate tra after death.  "I Director: After this certificate has been signed by the attending physicial by the funeral director, page 2 should be detached for use as the bu		23b. Was decedent proposed 12 months?		1 Live b	irth ant at time of d	2	Fetal deal	`	Ectopic	pregnancy		- 1	Month	Da	y Y	ear
ires that the signed by the be detached	ক্র	Part II. Other signification			death but not	resulting in	the underlyi	ng cause g	jiven in Pa	rt I.		_		_	e cause of de bly 4 🗹 Un	
Division of Vital Records, P.O. B to the Hospital or Attending Physician: The law requires that the d within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Completed										24a. Was autop perfo 1 Yes	osy rmed?	prid dea		psy findin <b>gs</b> a npletion of ca 2	
Vital ysician: his certif director,	Be	25. Was case referre examiner? 1 ✓ Yes 2	d to medical	Hospital: 1	npatient 2	ER/Outp	atient 3		of Death (			Reside	nce 6 🗸	Other: 8	Scene	_
on of cending Phatth.	tion: T	27. Manner of Death  1 ✓ Natural	5 Pendir	ng	of Injury , Day,Year)	28b. Tin	ne of Injury		ry at Work	- 1	d. Describe	how inju	iry occurred			
Division  Division  To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 4 Homicide	6 Could determ	not be 28e. Place	e of Injury - At I	home, farm	, str <b>ee</b> t, facto	ory, office b	uilding, etc	28	f. Location ( or Town, S		nd Number	or Rura	I Route Numb	per, City
o the Hos	Medical (	(		sician: To the bes iner: On the basis of and manner si	of examination											
	Ĭ.	29b. Signature and ti	>4	. Kert	TR. M	uc D	2	9c. License O.C.I					ober 28,		h, Day, Year)	
8		36. Name and address Theodore M.		MD. Assista	e of death (Iter nt Medical	Examin	er 111 F	Penn Str	eet, Bal	timore, I	MD 2120	1				
Sta		31. Date filed (Month)		32. Re	gistrar s Signa	Parks	1									

10-08324 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Corey Phillips State of Maryland / Department of Health and Mental Hygiene 2010 34290 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day October 31, 2010 Medical Examiner 1642 hrs Corev Phillips 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Johns Hopkins Hospital 5. Social Security Number If Under 1 Year I if Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In vrs. last birthday) **Funeral** Foreign Months Director 216-84-2629 Country) MD 1 X M 2 F 40 03-23-70 Usual Residence of Decedent any 10c. City, Town or Location 10d. Inside City Limits or 28a-f show XX Yes 2 No s 23a or 28a-f show e notified at once. MD NA Baltimore hours after death with the Maryland Director 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? 1627 Ν. Milton Avenue 21213 USA Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. African Never Married 2 X Married 2 X No Yes 5 3 Widowed If Yes, Give Year Yes 2 No specify: 4 Divorced Specify: American à 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filled within 72 lent of Health and Mental Hygiene.
ant: If item 27 is marked other than ", or other traumatic event, the Medical E. 10th Grade NA Organist Church 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Elmer Stevenson Patricia Α. Phillips 19a. Informant's Name/Relationship (Type, Print) Mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia A. Phillips 2325 Barclay Street Baltimore, MD 21218 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Baltimore, Trinity Cem. 1 X Burial 2 Cremation 3 Removal from State 11-08-10 Dundalk, MD Donation 5 Other Specify. 21. Signature of Funeral Service Licens 22. Name and Address of Facility Wylle Funeral Home P.A. 638 N. Gilmor Street Baltimore, MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval Between Onset and failure. List only one cause on each e.e. Medica Death Immediate Cause (Final disease Aortic Dissection Examiner or condition resulting in death) Due to (or as a consequence of) b. Hypertensive Cardiovascular Disease Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last certificate be executed and Physician/Medical attending physician a for use as the burial -X UNPENDED AMENDED #23a,b,27perME,G909,11/29/2010,WS Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy 2 Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed Records, has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) of Vital director Be Other<sub>4</sub> Nursing Home 5 Residence 6 Other: 1 🗸 Yes After this No the funeral 28a. Date of Injury (Month, Day, Year 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Division after death. Pending 1\_\_\_ Yes 2\_\_\_ No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City hours after 3 Could not be Suicide or Town, State) within 24 hours at To the Funeral I determined Homicide completely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 1, 2010 30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

31. Date filed (Month, Day, Year,

NUA 03

OCME

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ CARMELLA PANARELLO October 27. 2010 8:15  $\mathbf{p}_{\mathsf{M}}$ Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death N/A Examiner 4b. City, Town, or Location of Death Baltimore St. Johns Assisted Living 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 28,1918 **Funeral** 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 🗆 M 2 🗷 F Days Hours Min. 92 Director 095-18-5156 Usual Residence of Decedent or 28a-f shov 10b. County 10a. State 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director 10d. Inside City Limits N/A Maryland Baltimore 1 🗶 Yes 2 🗆 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21231 1817 Fleet Street U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, or. 1 Never Married 2 Married Black, White, etc. Completed by ☐ Yes Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🗷 No Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important; If item 27 is marked other tha any injury or other traumatic event, the N Domestic Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Letterio Panarello Anastasio Antonia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marge Parker (Niece) 134 Billings Avenue, Paulsboro, New Jersey 08066 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Atlantic | Crematory 10-28-10 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 130 East Fort Avenue, Baltimore, Maryland 21230 23a. Per 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between ock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death signed by the a d be detached f 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Tes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: ပ္ 1 Yes 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) License number Name and address of person who completed cause of death (Item 23a

DHMH 17 Rev 7/2009

State Registrar Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b Per FH G909 11/17/10 JH
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Migdle, Last) 2 Date of Death 3. Time of Death Physician/ 30 Day 16:35 PM Medical Examiner Facility Name (if not in stitution, give street and 4h City Town or Location of Death 4c. County of Death Baltimore n/a If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕱 M 2 🗆 F Months Days Hours Min Month, Day, June 13 243-46-9307 76 Director 934 NC Usual Residence of Decedent 28a-f shov 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director MD n/a 1 ☐XYes 2 ☐ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5001 Conant Way Apt.L 21206 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 □X/es 2 □ No Black, White, etc. by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Army 1 ☐ Yes 2 X No Specify. Black Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 9th Laborer Bethlehem Steel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Dewitt Peters Svlvester 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aloha Peters/Daughter 1818 W. Lexington St. Baltimore, Md 21224 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Nov  $17^{\circ}.2010$ cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GarrisonForestVet Nov. 10,20 00wingsMills,Md Funeral Service 22. Name and Address of Facility 2121 MD 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause the children. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ no Ca (cinomo disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions if any leach of the cause. Enter Underlying Examine Due to for as a consequence of attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year been signed by the should be detached Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📈 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has b lirector, page 2 sl autopsy perform death? 2 🗌 No Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? 1 Tyes 2 X No Other: ဂ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death.
Funeral Director: After this eted filled in by the funeral dir 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 ho

To the Fune

completed fi (Check only one 3 Certifying Marse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b 11-1-2010 leted cause of death (Item 23a) (Type, Print) 30. Name and add ave 1 filed (Month, Day, Year) 32. Registrar's Signature State

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Registrar

4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month SELMA POLLACK ochober 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Hospital Baltimore 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth Birthplace (State or Foreign Country)
 MD 14 **Funeral** 1 M 2 X F Hours 027197 1926 **Director** 215-22-4296 84 Yrs. なる Usual Residence of Decedent 28a-f show th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location with the Maryland Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6711 DARWOOD DRIVE 21209 · POLJACK 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify 3 → Widowed 4 □ Divorced Specify: WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) BROKER REAL ESTATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ SAMUEL SINGER Known REBECCA PUZNIACK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau MERLE INTNER / DAUGHTER 3407 FIELDING ROAD, BALTIMORE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗔 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH EL MEMORIAL PARK 11/01/2010 RANDALLSTOWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21209 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Aspiration pneumonitis disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) sician and burial-transit Exami The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician sthe burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month signed by the a JYes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No 1 Yes Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident
Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number RES-000 Maryon October 30, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pandy Many

3:23

10d. Inside City Limits 1 🗌 Yes 2 ី No

Approximate Interval Between Onset and Death

Dav

No No

Year

N/A

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State Registrar

10-08254	
Kenneth Ross	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Kenneth Ross		1- For State	tate of Maryla		artment of rtificate of		d Menta		201	0 34294
Physici Medical Exam		Registrar  1. Decedent's Name (First, Midd  Kenneth Lee						2. Date of De Month October 2		3. Time of Death
		4a. Facility Name (if not instituti Johns Hopkins Bayvi	on, give street and nur	nber)		b. City, Town, or Baltimore	r Location of D		4c. County of E	
Funeral Director		5. Social Security Number 215-86-1329		7. Age (In yrs. I	last birthday)	If Under 1 Year		T	irth(MM/DD/YYYY) 9	I. Birthplace (State or oreign Country) MD
ıny		Usual Residence of Decedent  10a. State 10b. County			, Town or Locati			TOCE.	29,1907	10d. Inside City Limits
aryland 8a-f show any at once.	tor	MD  10e. Street and Number	N/A		В	altimor	re			1 X Yes 2 No
nth the Maryland 23a or 28a-f sho notified at once.	Director	4538 Parks:	ide Drive	:		10f. Zip Code 21	206		10g. Citizen of What USA	ŕ
hours after death with the Maryland natural", or items 23a or 28a-f sho Examiner must be notified at once	Funeral	11. Marital Status  1 Never Married 2 M  3 Widowed 4 Div		edent Ever in U rces? 2 No	If Y	es, specify Cubar	n, Mexican, Pu	( Specify Yes or Ne erto Rican, etc.)	White, e	
2 hours aft "natural" Examine	ted by	15. Decedent's Education (Spe Elementary/Secondary (0-12)	Lor Dates: ecify only highest grade		16a. Decedent	Yes 2 X No 's Usual Occupa' ost of working life	tion (Give kind		16b. Kind of Busin	•
21215-0036 uld be filed within 72 Mental Hygiene. marked other than " c event, the Medical 1	Completed	12th Grade  17. Father's Name (First, Middle				Housek	_	ame (First, Middle,	Johns H Bayview Maiden Surmame)	Opkins Hospital
21215 ald be file Mental Hy marked o	To Be (	James Winsto	on Ross,	Sr.	19b. Mailing		Agnes	Louise	Fleming	
MD nd 2 sho ulth and m 27 is aumati	_	Jacqueline I			4538	Parksi	lde Dr	ive Bal	timore,	MD 21206
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 XX Burial 2 Cremation 4 Donation 5 Other S 21. Signature of Funeral Service	pecify:	m State	crematory or oth aklawn	er place) Cemete	ery 1	1/4/10	Baltimo	re, MD
Physician Physician		23a. Part I. Enter the disease, or	Harris	sed the death.	[42]	lo Bela	air Ro	ad Balt	imore, M	uneral Home D 21206
/Medical Examiner		failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line.	Arrhyt	hmia					Between Onset and Death
	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a c			-		· -		
ped :	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c	onsequence of	f):					
O, e be executed ysician and burial - transit		X UNPENDED	d AMENDED #	23a 27n	erMF CO	11 1/12	/2011 W			
Box 6876 death certificat the attending phydror of for use as the	hysicia	# 23a.27perME.G911.1/12/2011.WS  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown    No 9 Unknown   9 Un								
ires that the signed by the detache	2	Part II. Other significant condit	ions contributing to c	leath but not re	esulting in the un	derlying cause g	iven in Part I.			e to the cause of death?  Probably 4  Unknown
of Vital Records, P.O. ag Physician: The law requires that to there this certificate has been signed by meral director, page 2 should be detac	Completed							24a. Was autop perfor	sy prior med? death	
Vital Reconsisions: The this certificate	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:	patient 2	ER/Outpatient		of Death (Che		Residence 6 0	ther:
ion of tending Pheath.	ation: T	27. Manner of Death  1 X Natural 5 Pend	28a. Date of (Month, D stigation	Injury ay,Year)	28b. Time of Inj		y at Work? es 2 No	28d. Describe	now injury occurred	. <u> </u>
Division To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could 4 Homicide deter		of Injury - At ho	me, farm, street	factory, office bu	uilding, etc.	28f. Location (S or Town, S		Rural Route Number, City
To the Hos within 24 h To the Fur completely	edical	one) 2 Medical Exam	nysician: To the best of miner: On the basis of and manner state	examination an						
	2	29b. Signature and title of certifie				29c. License O.C.M			October 29, 20	,
			istant Medical Ex	aminer 1	I11 Penn St	eet, Baltimo	re, MD 212	201		
Sta Registi		31. Date filed (Month, Day, Year)	32 Regin	trar's Signatur	pair	i)				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Town, or Location of Death Examiner 4c. County of Death timore If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. Hours Country) Director 28a-f show 10c. City, Town or Location 10a. State 10d. Inside City Limits notified at Director 1 Yes 2 No more 10f. Zip Code 10e. Street and Number ò 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a o other traumatic event, the Medical Examiner must be Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? 1 Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married 1 Yes Give ģ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working should be filed within 72 and and Mental Hygiene. ife. DO NQT use retired) Be Father's 18. Mother's Name (First, Middle, Maiden Surname) 2 hardse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health of Item 27 i 80 20b. Place of Disposition (Name of cemetery crematory or other p 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) 21. Signature of Euneral Service Licensee MOI 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Gastrointestinal breeding **≱** Medical Due to (or as a consequence of) Examiner Rectal Mass Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) -transit Methstatic lung cancer and Due to (or as a consequence of) burial attending physician for use as the buria Physician/Medical that the death certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Records, 1 ☐ Yes 2 ☐ No 3 XProbably 4 ☐ Unknown Completed certificate has been si rector, page 2 should i 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performe Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No After this certific funeral director, Division of Vital Be 26. Place of Death (Check only one) Hospital: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 YOther (Specify) HoSDICP 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation within 24 hours after death

To the Funeral Director: completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 00070635 10129110 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pate chanes N 32. Registrar Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month RICE COBERT OCTOBER 2010 5:40 Medical 4a. Facility Name (if not institution, give street and number) 4b. **Examiner** City, Town, or Location of Death 4c. County of Death RANDALLSTOWN BALTIMORE NORTHWEST HOSPITA If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** 217-62-2306 Director ral", or items 23a or 28a-f show Examiner must be notified at death with the Maryland 10a, State 10b. County 10d. Inside City Limits Director 1 Yes 2 No more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 X Yes If Yes, Give 2 No filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 M No Specify: "natural" Completed 3 Widowed 4 M Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life D NOT see retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. the Kooter Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Numb Gay Page 1 and 2 wens (Sister 20a. Method of Disposition 20b. Place of Disposition (Name of Location - City or Town, State Date cemetery, crematory or other place) ■ Burial 2 □ Cremation 3 □ Removal from State permit. Page Department 4 ☐ Donation 5 ☐ Other (Specify) 11-6-2010 21. Signature of Funeral Service Deensee 5 23a. Part 1. Enter de disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ BLEEDING disease or condition - ASTROINTESTINAL Medical resulting in death) Due to (or as a consequence of) Examiner DISSEMINATED 48 HPS INTERVASCULAR COMGULOPATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examine Due to (or as a consequence of): The law requires that the death certificate be executed 48 ARS SEPSIS signed by the attending physician and deetached for use as the burial-trar Due to (or as a consequence of): resulting in death) Last PHEUMONIA WEEK IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Dav Year 2 No g Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by END STAGE RENAL DISEASE 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? MYOCARDIAL INFARCTION 24a. Was an After this certificate has autopsy OBESITY MORBID Yes 2 No 1 Yes 2 No Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 XNo မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred injury Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 1 Certifying Physician: To the pest of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the base of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nursa Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature D0060293 2010 OCTOBER 28. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OLD COURT RD. RANDALLSTOWN 21133 MD 5401 MURTUZA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 26 per verb., g909,11/03/2010 and Mental Hygiene Certificate of Death Reg. No. 34297 1 - For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** October 18, 2010 Elmer Casimer Rudis 12:15 P M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 124 W. Franklin Street; Apt 406 Baltimore 8. Date of Birth (Month, Day, Jan 12, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Min. Year) 1925 Days Hours 1 № M 2 □ F Months Maryland 212-26-2970 85 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show if item 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Modical Examiline mass be notified at Director Baltimore 1⊠Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21201 USA 124 W. Franklin St; Apt 406 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. 1 ∏Yes 2 ☑ If Yes, Give Year or Dates: 1₺ Never Married 2 Married 2 **⊠** No Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🖾 No Specify: 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation within 72 h (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) 12 College (1-4or 5+) laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other trauments Marion Demka Kazimiras Rudis ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7203 Johnnycake Road; Catonsville, MD 21228 Barbara Moore - niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board 21. Signature of Funeral Service 655 W. Baltimore Street; Baltimore, MD 21201 23a. Pant. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical of as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examine requires that the death certificate be executed Due to (or as a consequence of): burial-P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed' 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \( \sum \) Nursing Home 1 ☐ Yes 2 ☐ Ño Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 □ Yes 2 □ No 2 Accident investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) within 2 To the I 29b. Signature and title of certific 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 413 Commonwealth AUR. BAY.MD 21228 HEREDIA

Registrar

DHMH 17 Rev 1/2001

State

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For Amen State Registrar	d Item	s 29c,d	of Maryland	and / Dep	gronen ertificate	Of De	<b>2010am</b> eath	Mental Hy	gien Reg. N	e .2010	31,298
Physician/			1. Decedent's Name (Fire							2. Date of Death 3. Time of Death				
	Medic	cal	Nancy 4a. Facility Name (if not i	Inetitution div	Jean	nher)	Radfo	_		and an of Don	Octobe		2010 Year	1:55 P M
Town of	Examir	ner	Casev Hou		e street and nur	nberj		1	own, or Lo Rockv	ille	ın	4	c. County of Dea Montgo	
	Funeral		5. Social Security Number	er 6.	Sex 1 □ M 2 🔽 F	", "	rs. last birthday)	If Under Months		f Under 24 Hrs Hours Min			g. Bir	thplace (State or Foreign
	Director		220-32-501 Usual Residence of Dece	1	X-	88	Yrs.				June 2	6.	1922   New	Hampshire
	/land f shov d at	tor		o. County		10c.	City, Town or L	ocation	C41	C	ina			10d. Inside City Limits
	e Mary r 28a- notifie	Director	MD  10e. Street and Number		omery			105 7in		er Spr	Liig			1 ☐ Yes 2X No
	with th 23a o ist be		9907 Blund					10f. Zip		902		-	Citizen of What Co United S	
	death vitems	Funeral	11. Marital Status		12. Was Dece	edent Ever in	U.S. 13.	Was Decede	nt of Hispa		ipecify Yes or No-		14. Race - Ame	
36	after or samir	d by	1 X Never Married 3 Widowed 4 Widowed		If Yes, Giv			1  Yes 2			to moun, etc.,		Black, Whit	<sub>e, etc.</sub> White
-00	hours natura lical E	lete	15	. Decedent's			16a. Dece	edent's Usual	Occupation	on		16b.	Kind of Business	Industry
21215-0036	hin 72 ne. <b>than</b> "l e Mec	Completed	Elementary/Seconda	· · ·	rade completed, College (1		(Give	OO NOT use	retired)	ng most of wo	rking	1		
	ed witi Hygiei <b>other</b> i	l o	17. Father's Name (First,	Middle, Last)	4			Libr	arian		me (First, Middle,			Congress
lan	d be fil dental irked o	2	Herbert	F.	H	low1and	1			Lois	A.	, marcei	(Unknow	m)
Maryland	should and N is ma rauma		19a. Informant's Name/f										or Town, State, Zij	
	and 2 Health em 27		Allison G. 20a. Method of Dispositi		er / Fri		o. Place of Disp			r., 51	lver Spr		Location - City or	Town State
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 Burial 2XXC 4 Donation 5	remation 3		_	cometent cre	matani or atl	nor nlacal	y 10/	23/2010	ı	ltsville	
Balt	permit. Departi Import any inj		21. Signature of Funeral	Service Licer	see mem	M003	382 3	2. Name and Rapp F	Address o unera st Av	of Facility I and Ie. Si	Crematio Iver Spr	n S	ervices	:0910
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	Medical Examiner		resulting in death)	ſ	Due to	(or as a cons	equence of):							
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3760	ificate ig phy as the	Medi	IF FEMALE.		d									
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#29 A 3 P.O. Box 687	re dear	Completed by Physician/M	1 ☐ Yes 2 🔀 No 9 ☐ Unknown		4 ∐ Preg 9 ☐ Unkr	nant at time on	of death 5 l	☐ Other <i>(spe</i>	cify)				Month	Day Year
O.A.	that the ned by e deta	by Pi	Part II. Other significant	t conditions	contributing to d	leath but not	resulting in the	underlying ca	use given	in Part I.	23e. Did t	obacco	use contribute to	the cause of death?
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200	law re has be e 2 sh	mple									24a. Was auto		prior to	topsy findings available completion of cause of
N. C. S.	in; The ificate or, pag	ပ္ပ	25. Was case referred to	medical					26 Place	of Death (Che	1 ☐ Yes			3 2 No
Vita	lysicia lis cert direct	To Be	examiner? 1 ☐ Yes 2 🗓 No		Hospital:	Inpatient 2	☐ ER/Outpatie	nt 3 🗆 DO/	TOther:	-		dence	6 X Other (Spec	Hospice
# 50	Attending Physician: The law requires that the death certificar death.  sctor: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as			Pending		of injury th, Day, Year)	28b. Time o injury	f 28	c. Injury at work?		28d. Describe h			
Division	Attener deat ector:	Certificate:	2 Accident 3 Suicide 6 4 Homicide	Investigation Could not industry determined	28e. Place	of Injury - At	home, farm, st			3 2 LI NO				ral Route Number,
οį	ital or urs afte ral Dir lled in				bullal	ng, etc. (Spec					City or Tov			
	To the Hospital or Attanding Physician: The law requires that the dewinthin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached	Medical	(Check 2 □ N	∕ledical Exam	iner: On the bas	sis of examina	tion and/or inves	stigation, in m	y opinion, o	death occurred	at the time, date a	and plac	and manner as state, and due to the day, and due to the day, and manner as	cause(s) and manner stated.
	To t vith		29b. Signature and title o	of certifier	Λ.				License nu <b>06063</b>				ate signed (Month tober 22	
3			30. Name and address of <b>Bindu C.</b> J	f person who Joseph	completed caus	se of death (It	em 23a) (Type, uncaste	Print) r Mill	Road	l, Rock	ville, N	1D 2	.0855	
	Stat Registra		31. Date filed (Month, Da				negre da							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#26perPHYS#30perDVR, G909, 11/3/2010, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2<u>010</u> Physician/ NOV. DOROTHY M. ROBINSON 5:45A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Harford 801 Gail Ct. Fallston Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗓 F Months Days Hours July 7, 1916 94 212-26-6860 Director Maryland Usual Residence of Decedent fshow 10b. County "natural", or items 23a or 28a-f sho 10c. City, Town or Location Pace 1 and 2 should e filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Baltimore 1 Yes 2 No Maryland Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Be Completed by Funeral 17 Brook Farm Court 21128 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes ※※ No Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes XX No Specify: If Yes, Give 3 Divorced Year or Dates Department of Health and Mental Hygiene. Important If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 9th grade Cook Andy's Lounge 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William E. Isett Ethel M. Macabee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Colleran (Daughter) 17 Brook Farm Ct. Perry Hall, Md. 21128 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parkwood Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 11-4-2010 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) permit. Signature of Funeral Service Licensee . Name and Address of Facility assann Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each line ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine attending physician and for use as the burial-transi To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death 5 Other (specify) Year 9 Unknown Other significant conditions contributing to death but not resulting in the underlying pause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Director: After this certificate 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Granddaughter T examiner? Other: 4 \( \text{Nursing Home} \) \( \text{Desidence} \) \( \text{Other (Specify)} \) \( \text{Residence} \) Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 K Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 Mary E. Carroll 9110 Philadelphia Rd. Ste. 108 Baltimore, MD 21237 31. Date filed (Month, Day, Year) State 32. Registra Signat Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month SANDRA ROGERS 1615PM 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death JOHNS HOPIKINIS BAYVIEW MEDICAL CENTER BALTIMORE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Funeral 1 M 2 XF Days (Month Day, 216-48-0477 **Director** 62 Usual Residence of Decedent show 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 No NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 603 N. Highland Avenue 21205 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. African Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No 3 Widowed 4 N Divorced Specify: American 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) it. Page 1 and 2 should be filed within 72 P rtment of Health and Mental Hygiene. vrant: If item 27 is marked other than "n njury or other traumatic event, the Med (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Grade John Hopkins Hosp. 2y<u>rs.</u> Dietician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Louie Anderson Lillie Mae Foster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly Harmon-Daughter 402 N. Kenwood Avenue Baltimore, MD 21224 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place Arbutus Mem. Pk. 11-05-10 4 ☐ Donation 5 ☐ Other (Specify) Arbutus, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Interval Between Immediate Cause (Final disease or condition Physician/ PEA ARREST Medical resulting in death) Examiner ARDIAC ARRHYTHMIA Sequentially list conditions, it any leading to in reduct cause. Enter Underlying Examin 2 DAYS HUPERIKALEMIA burial-transi Cause (Disease or linjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months? Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? death? 1 Yes 2 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: မှ 1 Npatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at (Month, Day, Year) 1 Natural 5 Pendina 1 Yes 2 No Accident
Suicide Investigation 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifiei 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier MD RES MOL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TANYAPCRN WANSOM, MD 4940 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar DHMH 17 Rev 7/2009 **ORIGINAL** 

EASTERN

AND BALTIMORE, MD 21220

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCT Month 2010 30 5:53 P M Elizabeth May Rainey Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Carroll Westminster Dove House If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖺 F (Month, Day, Year) 1/16/1924 85 Months Hours **Director** 212-20-3021 MD Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits 1 Tes 2 No MD Carrol1 Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 298 Beacon Mews Ct 21157 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 X Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: 3 Divorced Specify: White Year or Dates : If item 27 is marked other than "natur or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Her Home Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oft any injury or other traumatic augant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ William Volland Elizabeth Klotz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patrick Rainey/Son 3024 Bird View Rd., Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 11/9/2010 cemetery, crematory or other place) 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Garrison Forest Vet. Cem. Owings Mills, MD Signature of Funeral Service License <sup>22</sup>Burrater Queenty Funeral Home & Crematory, 1212 W. Old Liberty Rd., Winfield, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician. disease or condition resulting in death) Medical Due to (or as a consequence of): Éxaminer Sequentially list conditions, Due to lores a consecuence of cause. Enter Underlying been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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Director: A

d in by the f Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

within 24 hours after de To the Funeral Directo completed filled in by th

State Registrar

Medical

29a. Certifier

(Check only one 29b. Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Sig

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

ater Street WESTINDSEL, LID 2115

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Midgle, Last) 2. Date of Death 3. Time of Death Kobinson Physician/ Mont 0 4a. Facility Name (if not institution, give street and number) 2010 Medical 4c. County of Delat 4b. City, Town, Location of Death **Examiner** Timore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country Mary lan 1 1 M 2 D F Months Days Min. Yrs. Director Usual Residence of Decedent or items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "---any injury or other than." State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Mar an 1 ☑ Yes 2 ☐ No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? by Funeral 3302 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 No 1 Yes 2 No Black If Yes, Give 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Laşt) 18. Mother's Name (First, Middle, Majden Surname, မ Beatney Matthews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) dans aulette Battimore tpoleton 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or oth Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility lar 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events Examiner Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Other (specify) Day Pregnant at time of death g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 X No 3 ☐ Probably 4 ☐ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Tes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 2 🗌 No Accident Investigation Suicide Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, it my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

State

201

E, UNIVERSITY PARKWAY, BALTIMORE, MD 21218

address of person who completed cause of death (Item 23a) (Type, Print)

UNION

31. Date filed (Month, Day, Year)

MEMORIAL HOSPITAL

32. Registrar's Signature

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OCTOBER

Saltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

MAHINDOKHT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Year 1104 AM Pauline Riordan Detoner 2010 Medical 4a. Facility Name (if not institution, give street and number 4b. City Town, or Location of Death 4c. County of Death Examiner Shady Grove Hospita Kockville Montgomery Adventist 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F Months Hours Min June 19. Indiana 020-42-3314 95 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director 1 X Yes 2 ☐ No Maryland | Montgomery Gaithersburg 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 30(10 Funeral 301 Russell Avenue # 208 20877 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1942–1946 1 ☐ Yes 2 🖾 No Specify: Specify: White 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Registered O.R. Nurse Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ William Bennett Mary Kellett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet M. Riordan / Daughter 11125 Rutledge Drive North Potomac, Maryland 20878 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State December 1 X Burial 2 Cremation 3 Removal from State Arlington National Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Arlington, Virginia 2010 Furieral Service 21. Signature & Robert A. Pumphrey FuneralHome—Rockville, Inc. 300 W. Montgomery Avenue Rockville, Maryland 20850 MO1607 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final EPSI h sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** INFECTION URIWARY 2ACT Sequentially list conditions, Examiner day, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to forms a consequence of attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death 5 Other (specify) signed by the a Unknown g Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown plnods 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an s certificate has be lirector, page 2 s performed? Yes 2 No 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 **2** No 1 🗌 Yes Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 5 Pending Natural 1 Yes 2 No neral Director: A filled in by the fi Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 10057124

Registrar DHMH 17 Rev 7/2009

State

Trivona

31. Date filed (Month, Day, Year)

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Molec

Rockville MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MeD

10110

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month Nils Hans Anders Swanson Nov. 2010 Α Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Casey House Rockville Montgomery Social Security Number 7. Age (In vrs. last birthdav) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) New York **Funeral** (Month, Day, ) March 25 1 🕅 M 2 🗆 F Months Days Hours Director 093-22-5079 80 1930 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County be filed within 72 hours after death with the Maryland Completed by Funeral Director 10c. City. Town or Location 10d. Inside City Limits MD Montgomery Bethesda 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5921 Rossmore Dr. 20814 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Physicist Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Sven Hilding Swanson Karin Linnea Svensson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Linda J. Swanson / Wife 5921 Rossmore Dr., Bethesda, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation Other (Specify) Chesapeake Crematory | 11/2/2010 Beltsville, MD Signature of Fu ice Licensee Rapp Funeral and Cremation Services Gist Ave., Silver Spring, MD 20910 23a. Part nter the disease, or complic Ins that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Duodenal Cancer Medical Due to (or as a consequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year Yes 2 🗆 No been signed by the should be detached 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perform 2 No 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6 Other (Specify) 2 No 1 🗌 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death

Natural

Accident 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 4 Homicide determined

Division of Vital Records, P.O. Box 68760 **Director:** n 24 hours after de ne Funeral Directo pleted filled in by t within 2

 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practionar. To the cause of (Check only one late and place, and due to the causes) and 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D37142 November 1, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Geoffrey Coleman 1355 Piccard Dr., Rockville, MD 20850

State Registrar

Medical

32. Registar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Robert Preston Stewart 4:00 AM M 2010 October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Laurel 5808 Parkway Drive If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Funeral Age (In vrs. last birthday) New York Aug. 24, <sup>Y</sup>1946 1 □ XM 2 □ F 64 Director 121-36-4870 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. Hant: If item 22 is marked other than "natural", or items 23a or 28a-f sho lury or other traunnatic event, the Medical Examinar must be notified at jury or other traunnatic event, the Medical Examinar must be notified at Director Maryland Prince Georges Laurel 1 ☐ Yes 🏋 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20707 5808 Parkway Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married ▼ Yes 2 □ No f Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 3 <sup>College (1-4 or 5+)</sup> American Federation of Elementary/Seconday (0-12) Manager of Field Auditing Teachers Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည Maisie C. Livingston Robert W. Stewart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 410 Prince Georges Street, Laurel, Maryland 20707 Rev. Sheila McJilton - Executrix 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or oth Cemetery crematory or other place)

Tvy Hill Cemetery 1 X Burial 2 Cremation 3 Removal from State 10/30/2010 Laurel, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Flock Funeral Home, Inc. 21, Signature of Funeral Service License 7601 Sandy Spring Road, Laurel, Maryland 20707 MO1283 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician months disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine This to (or all a consequence of) To the Hospital or Attending Physician. The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 L Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 🗌 Yes 2 🚟 Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: 잍 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 **Secretifying Physician:** To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Columbia No 21044 6020 Educard 10716 Charter 31. Date filed (Month, Day, Year 32. Registrar's Sign State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ALTER Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Mandrin Hospice House Anne Arundel Harwood Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs Hours Min. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 M 2 - F Months (Month, Day, Year Tennessee Director 408-50-6530 78 Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, <u>the Medical Examiner must be notified at</u> 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1**X**□ Yes 2 □ No Maryland Prince Georges Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12329 Tilbury Lane 20715 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 A Yes 2 1951 - Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. þ 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Telephone Lucent Technologies Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be file trent of Health and Mental I rtant: If item 27 is marked c ည Mack E. Smith Quincy Meredith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary A. Smith/ Wife 12329 Tilbury Lane Bowie, MD 20715 other 20a. Method of Disposition
1 □ Burial 2 Å Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or oth Baltimore Washington 11/4/2010 4 ☐ Donation 5 ☐ Other (Specify) Laurel, MD 21. Signature of Meral Service 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a, Part 1, Enter the dis complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final disease or condition Pnysician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last the Hospital or Attending Physician; The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) ed by the attending physician detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe this certificate 1 Yes 2 No Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical a 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Ather (Specify) MANDEL N 2 **R**o Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of After t 28c. Injury at 28d. Describe how injury occurred HOUSE 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation within 24 hours after deat To the Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Fertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 KRIEGE 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State Registrar

DHMH 17 Rev 7/2009

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Medical Exami	ner	Kyten witte						Month October 2	Day Year 7, 2010	1504 hrs
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death								
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Funeral		5. Social Security Number		Age (In yrs. la	ist birthday)	If Under 1 Ye Months Da		Min	th(MM/DD/YYYY) 9. E Fore	ian
Director		213-98-8742	1 M 2 F		29 Yrs.	IIIO IIII D	1,00.0	09–30 –	1981	country) Maryland
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faryland 28a-f show Lat once.	tor	Maryland Howai	ra	_	Ellicott (	10f. Zip Code			0g. Citizen of What Co	
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15-0036 flicd within 72 hours after death with the Maryland I Hygiene. Ad other than "natural", or items 23a or 28a-f she 1. the Medical Examiner, must be notified at once	Funeral	1 XXNever Married 2 M	arried Armed Force	es?				r (Specify fes of No ruerto Rican, etc.)	White, etc.	encan ingian, black,
fler de		3 Widowed 4 Div	orced If Yes, Give Year	2 <u>X</u> No	1 \	res 2X N	lo specify:		specify: B	lack
ours a atura	d by	15. Decedent's Education (Spe	or Dates: cify only highest grade o	completed)	16a. Decedent's	Usual Occup	ation (Give kin		16b. Kind of Business	/Industry
72 hc	Completed	Elementary/Secondary (0-12)	College (1-4 d	or 5+)	during mos	st of working li	fe. DO NOT us	se retired)		
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica		17. Father's Name (First, Middle,	, Last)				1	Name (First, Middle, M	Maiden Surname)	
d be i	Be c	Jerry Seals  19a. Informant's Name/Relations	Li- (T Di-A)		40h Mallina	Address (O)		rly White	nber, City or Town, Sta	
e, MD 21215-00; I and 2 should be filed with Health and Mental Hygiene item 27 is marked other to r traumatic event, the Meg	ပ		Father)			leathert			Maryland 2104	
ages I and 2 shount of Health and N	1 3	20a. Method of Disposition	- adici /	20b. P	Place of Dispositi			Date Date	20c. Location - City	
F ≈ % = 2	Н	1 X Burial 2 Cremation		Otate j	rematory or othe		1-	11 2 2010	01111-	M 11
Baltimo permit. Page Department of Important: injury or otd		4 Donation 5 Other Sc 21. Signature of Funeral Service		1 60.	lumbia Mer	me and Addre		11-2-2010	Clarksville	
Ba Depa Impa		11/1/1/1/					nolls Roa	Witzke Funera	al Homes, Inc a, Maryland 2	io.5
Physician	٦	23a. Part I. Enter the disease, or	complications that cause	ed the death.				diac or respiratory arre	est, shock, or heart	Approximate Interval
Medical	- 1	failure. List only one cause Immediate Cause (Final disease	1.4	shot Woun	d					Between Onset and Death
Examiner		or condition resulting in death)	Due to (or as a cor							
		Sequentially list conditions,	b							
	<u>.</u>	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a cor	nsequence of)	):					ed.
_ #	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a cor	nsequence of)	);					
760, icate be executed physician and the burial - transit	జ									<b>.</b>
be exician	흻	UNPENDED  IF FEMALE:	AMENDED							
760, ficate be g physici the buri	Ĭ,	IF FEMALE: 23b. Was decedent pregnant in th	23c. If yes, outo	ome of pregn					23d. Date of delive	•
Sox 6871 death certifica te attending pl	lä.	past 12 months?	I - Trae piliti	at time of dea		l death 3 <sub>r (</sub> Specify)	Ectopic pr	regnancy	Month	Day Year
Box 687 e death certific the attending p ed for use as th	Physician/	1 Yes 2 No 9 Unk	g Unknown		o ouie	(Opcomy)				
od by the etache		Part II. Other significant conditi	ions contributing to de	ath but not res	sulting in the und	derlying cause	given in Part I	. 23e. Did to	bacco use contribute to	
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter death.  al Director: After this certificate has been signed by the funeral director, page 2 should be detach.	d by							1 Yes	2 ✓ No 3 Pro	bably 4 Unknown
rds v requ	ig i							24a. Was a		utopsy findings available completion of cause of
ecc he lav ate ha	Completed							perfor	med? death?	'es 2 No
an: T		25. Was case referred to medical				26.Plac	ce of Death (Ch			
Vit;	o Be	examiner?  1 ✓ Yes 2 No	Hospital: 1 Inpa	tient 2 🔲 l	ER/Outpatient	3 DOA	Other N	lursing Home 5	Residence 6 🗸 Othe	er: Scene
of ing PI		27. Manner of Death	28a. Date of Ir	njury (,Year)	28b. Time of Inju	ıry 28c. İnj	ury at Work?	Subject shot	now injury occurred	
ion ttend feath.	읥	1 Natural 5 Pend 2 Accident Inves	oct 27, 201		FOUND: 1458 hrs	1	Yes 2 ✓ No	o Judjoot Shot		
ivis lor A after Direc	Certification:	3 Suicide 6 Coule	d not be 28e. Place of		me, farm, street,	factory, office	building, etc.	or Town, S	tate)	ural Route Number, City
Spita spita hours neral	Ö	4 Homicide deter	mined (Specify) S	ingle Fami	ily Home			11375 Heathe	rtoé Lane, Ellicott C	ity, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deached for use as the burial - transi	Sal	(Check only   Certifying Fi	nysician: To the best of miner:On the basis of ex							
To t with Com	Medical	29b. Signature and title of certifie	and manner state	d.			ise number		29d. Date signed (Me	
	-27	D_14 ].					.M.E.		October 28, 201	
	ŀ	30. Name and address of person	who completed cause of	f death (Item 1	23a)					
		Donna M. Vincenti, MI				enn Stree	t, Baltimore	e, MD 21201		
St	ate	31. Date filed (Month, Day, Year)	32. Regist	ar's Signatur	е					
Regist	rar	MOV 0.3 2010	Chrone B	gar	Kel					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle\_Last) 2. Date of Death October Physician/ 03.22 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hospital ge (In yrs. last birthday) Bal timore nes 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign 7. Age (In Date of Birth **Funeral** 1 🗆 M 2 🕱 F Hours Country) Director or 28a-f show 10a. State 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 No timore 10e. Street and Numbe 10g. Citizen of What Country 23a Funeral items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Never Married 2 Married "natural", or Completed by 1 Yes If Yes, Give within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 ₩ Widowed 4 □ Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 5th Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Sumame) Lonnie tal oar 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number of Daughter 1143 Wedgewood Road l homas ( 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) any Injury or Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) eadowridge 21. Signature of Funeral Service License Service 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Bleediv Immediate Cause (Final Rec tal Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter oncerning Cause (Disease or iinjury Due to (or as a consequence of): death certificate be executed the burial-transi and that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box ( 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Year Pregnant at time of death 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by è, Records, Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown director, page 2 should been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ◯ No 24a. Was an After this certificate has autopsy Be 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 Xinpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28b. Time of injury 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town. State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifie (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one Medical Residen October 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) lise 900 Caton Nath 21229 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 21 30 PM Nicholas Edward Smith. 10 28 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FRANKLIN SQUEGE HOSPITal Rosedale ctimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 🗆 F Days Hours Min April 20, 1931 79 213-30-9626 Director Maryland Usual Residence of Decedent 28a-f shov 10b. County with the Maryland ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Essex Baltimore 1 Yes XXX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14 Avenal Road 21221 United States or items death Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces? Black, White, etc ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 should be filed within 72 hours after If Yes, Give Year or Dates. Korean 1 ☐ Yes 2 🔀 No Specify "natural", Specify: Completed 3 X Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing 12 Years Plater Plater Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked other any injury or other there. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Almedia Jane Duncan Nicholas H. Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine J. Harper (Daughter) 14 Avenal Road Essex, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holly Hill Mem. Gdns. 11/1/2010 20c. Location - City or Town, State ₽ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Middle River, MD 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, Maryland 21222 Signature of Funeral Service Licenses 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician/ Archythmia Fatal Medical Examiner Due to (or as a consequence of) AtherosclorTic Arter Cosonary Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Due to (or as a consequence of) Exam Hypertension burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): nding physician a Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 D No Other: မ 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident
Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 2010 D54428

State Registrar

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32. Registrar's Signature

DR Balto Md Z1237

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IPKIN

michael

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Garnet Louise Saunders 2010 /Medical 4c. County of Death Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, If Under 1 Year If Under : Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 X F 220-24-6477 22,1926 MD Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I've I've Jical Exp. vir er must be a cult. A million or other traumatic event, I've I've Jical Exp. vir er must be a cult. A million or other traumatic event, I've I've Jical Exp. vir er must be a cult. 1 Yes 2 □ No Director Harford MD Havre De Grace 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21078 United States 710 Lewis Street Apt. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 M Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Reba Janette Cullum Robert Chester Murphy ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 710 Lewis St. Apt.6 Havre De Grace, MD 21078 Kim Ferguson/Daughter 3 APTIE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 27 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Chesapeake Crem. 2010 Beltsville, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License <sup>2</sup>C Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Dr. Towson, MD MO1585 Rebec Green Pastures Dr. Towson, MD 21286 Ackensor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due o (or as a consequence of): Examiner utinsin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last s a consequence of) Due to # Examiner the Hospital or Attending Physiclan: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, MURENT Physician/Medical the attending pl 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐ No this certificate has been signed by the all director, page 2 should be detached 9 Unknown 9 🗆 Unknown 23e. Did tobacco use contribute to the cause of death? Part JI., Other, significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by Ms Detlymism 1 Yes 2 No 3 Probably 4 Nonknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Umemia autopsy performe 2 LINO 1 ☐ Yes 2 ☑ No 1 TYes 25. Was case referred medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2 1 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 28d. Describe how injury occurred 27. Mannet of Death 28a. Date of Injury 28c. Injury at Work? After 1 (Month, Day, Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No I hours after death.

uneral Director: A
ely filled in by the fu 2 Accident 3 ☐ Suicide 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 241 10

State Registrar

31. Date filed (Month, Day, Year)

Serve & fack

HD6 WY 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) SCHWARTS 5 M **Physician** 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Baltimore Augsburg Lutheran Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07/09/1930 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days Hours Min 1 □ M 2 🛛 F Maryland 80 218-26-2107 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10h County 10c, City, Town or Location 10a State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Experience must be notified at 1 ☐ Yes 2 No Director MD Baltimore Perry Hall 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21236 10 Juilet Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 □Yes 2X No Specify: Specify: þ 3 ☐ Widowed 4 🕅 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaking Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Anna Marie Baumgartner James Russel Griffin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum once. 4015 Pinedale Drive - Baltimore, Maryland 21236 Donald R. Beutel (Per. Rep.) Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Michael Luth Ch. 11/02/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licensee 11750 Belair Road - Kingsville, Maryland Xassaln 21087 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, physician IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year for in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant 9 ☐ Unknown the ģ s been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. Division of Vital Records, 2 EIMERC 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 3510N 24a. Was an certificate has page 2 autopsy performe 2 No 1 ☐ Yes 1 Yes 2 No Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 To the Hospital or Attending Natural 5 Pending investigation n 24 hours after death. e Funeral Director: Af etely filled in by the ful 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier well

State Registrar 31. Date filed (Month, Day, frank.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TAS NEEM (AlUHAN), 285 Sm

32. Registrar's Signature

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2, Date of Death Month Day 28, 3010 Richard James Staples Physician/ 1:30 PM Medical 4a. Facility Name (if not institution, give street and number)

Doctor's Community Hospital 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Lanham Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛣 M 2 🗆 F Months Days Hours Min (Month, Day, Feb. 19 213-66-4311 56 19<u>54</u> Director Mexico Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits with the Maryland Director Greenbelt MD Prince George' 1 X Yes 2 ☐ No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? must be 20770 7822 Hanover Parkway Apt. 201 Funeral items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Armed Force Black, White, etc 0 by 1 Never Married 2X Married Yes 2 X No Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. I meter of Health and Mental Hygiene. I emer 27 is marked other than "natural", or uny or other traumatic event, the Medical Examil ury or other traumatic event, the Medical Examil. 1 Mayes 2 No Specify: Mexican White If Yes, Give Year or Dates Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Baltimore, Maryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) 12 Store Manager Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ C. Staples Laura R. Trevino Bradbury Penny L. Staples rint Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7822 Hanover Park., Apt. 201, Greenbelt, MD permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 11/01/2010 Woodbine,MD Journey Crem. 4 ☐ Donation 5 ☐ Other (Specify) Final 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21203 21. Signature of Funeral Service Licensee Borota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between
Onset and Death shock, or heart failure. List only one cause on each line Squamous Immediate Cause (Final Carcinoma Physician Medical resulting in death) D e to (or as a consequence of): Examiner Sequentially list conditions, if any leading cause. Enter Underlying Examine Due to or as a consequence of ng physician and as the burial-transit The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) led by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sate has been signed page 2 should be det by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 2 No 1 Yes 24 hours after death.
Funeral Director: After this certific eted filled in by the funeral director, Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tyes 2 2 No Other: မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d, Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) 4 Homicide determined Medical Effectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number 52815 29 10 2010 lexand 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Goodfoes Promise Drive Bowie MB2020 ander State

Registrar

Staples

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year 2010 Physician/ 6:15 PM October Mary k. Shoup Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Cherry Lane Nursing Center Laurel If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7 Age (In vrs. last birthday 8. Date of Birth Funeral Months Davs Hours Min (Month, Day, Year) May 17, 1926 Country) California 1 🗆 M 2 😿 F Yrs May Director 557-40-1546 Usual Residence of Decedent or 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State filed within 72 hours after death with the Maryland must be notified at Director 1 Yes 2 X No Prince George's Laurel MD 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code Funeral items 23a IISA 20708 9203 Pleasant Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status the Medical Examiner Armed Forces?

1 Yes 2 No "natural", or 1 Never Married 2 XMarried 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: White If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Washington and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Hospital Center Registered Nurse 12th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental+ Important: If item 27 is marked of any injury or other traumatir ၉ Helen VanDam Charles A. Kitching 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laurel, MD 20708 John D. Shoup/Husband Pleasant Court, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Kcremation 3 Removal from State 4 Donation 5 Other (Specify) 10/29/2010 Odenton, MD West Arundel Crem. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility  $\bullet$ 20707 313 Talbott Avenue, Laurel, M01103 23a. Part 7. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
WEEK Immediate Gause (Final Pnysician/ Septicemia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 1 year End Stage Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence on. Coronary Artery Disease 2 years Cause (Disease or linjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 \( \subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) the signed by the detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Diabetes Mellitus Completed peen s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an Hypertension has autopsy performed? Yes 2 No certificate Hyperlipidemia 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 💢 No 1 Inpatient 2 ER/Outpatient 3 DOA ျှ 24 hours after death.

Funeral Director; After this dieted filled in by the funeral dir 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 🔯 Natural iniury 5 Pending Natural
Accident
Sul-Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Chack within 24 3 onlylone 29b. Signature and title of certifier TTENDING 29c, License number 29d. Date signed (Month, Day, Year)

State Registrar our

31. Date filed (Month, Day, Year)

Michael Baako,

NOV 0 3 201

PATSICIAN

32. Resistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

D0057216

3450 Ft. Meade Road, #209,

October 29, 2010

Laurel, MD 20724

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State of Ma		oartment of H e <i>rtificate of D</i>			giene <sub>Reg. No.</sub> 2	010	34315			
			1. Decedent's Name (First, Middle, Last)				2. Date of Dea			3. Time of Death			
	Physicia Medic	Physician/ Medical AVIS SHIPLEY							Year 2010	6:30 A <sup>M</sup>			
	Examin	_	a. Facility Name (if not institution, give street and number)			Location of Death			unty of Death				
and the second			Encore at Turf Valley  5. Social Security Number   6. Sex   7. Age	icott Cit	8. Date of Birt		oward	lace (State or Foreign					
	Funeral Director	ľ	5. Social Security Number 6. Sex 7. Age 1 M 2 MF	(In yrs. last birthday, 103 Yrs.	Months Days	Hours Min.	(Month, Da	, Year) , 1907	Count	yland			
	>	t	Usual Residence of Decedent										
	yland f sho ed at	tot	10a. State 10b. County	10c. City, Town or L					1	0d. Inside City Limits 1 ☐ Yes 2XXNo			
	e Mar r 28a notifi	į.	MD Howard	Col	umbia 10f. Zip Code			10a Citizon	of What Coun				
	vith th 23a o st be	Funeral Director	6413 Allview Drive		210	46		rog. Onizen	US				
	eath v	<u>.</u>	11. Marital Status 12. Was Decedent Ev	ver in U.S. 13	J. Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spe	cify Yes or No-		Race - Americ	an Indian,			
036	be filed within 72 hours after death with the Maryland ental Hygiene. Wed other than "natural", or items 23a or 28a-f show feed other than "natural", or items 2a nor 28a-f show ic event, the Medical Examiner must be notified at.	þ	1 Never Married 2 Married 3 Widowed 4 Divorced  Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates.	No	1 Yes 2 X No		nicari, etc.)		Black, White, ecify: W	nite			
Maryland 21215-0036	"2 hour "natu edical	Completed	15. Decedent's Education (Specify only highest grade completed)	(Giv	edent's Usual Occupa e kind of work done d	ation luring most of worki	ng	16b. Kind	of Business Inc	dustry			
72	ithin itene.	Con	Elementary/Seconday (0-12) College (1-4 or 5-	F)	DO NOT use retired)  lephone Op	erator		C &	P Tele	ephone			
פַ	filed wall Hyg		17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle,	Malden Surr	ame)				
ylar	should be fill and Mental is marked of aumatic eve	٩	Lester Shipley			Geor	ge Swai	n					
lar.	should be file and Mental I is marked o	8 9	19a. Informant's Name/Relationship (Type, Print)	19b. Ma	iling Address (Street a			r, City or Tow	ın, State, Zip C	Code)			
αĵ	and 2		Ellen E. Eastman/Niece	20b. Place of Dis		w Drive,	Colum	oia, M	D 210				
Baltimore,	age 1 ant of nt: If it		1  ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cemetery, cr	rematory or other place Cemetery	e)	/2010		age Cer				
ᆵ	permit. Page 1 a Department of I Important: If ite any injury or of		21. Signature of Funeral Service Licensee		22. Name and Addres								
ñ	Der Jany		January 200K	M01103	313 Tal	bott Aver	nue, La	aurel,	MD 20	0707			
Ŧ	nysician/ Medical	1 4	23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Pneumonia  Due to (or as a consequence of):										
	Examiner		Due to (or as a	consequence of):									
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	consequence of):									
	ecuted and transi	Examiner	Cause (Disease or imjury that initiated events c.	consequence of):									
	cate be executed physician and the burial-transit	calE	resulting in death) Last										
1,60	icate g phys	<b>l</b> edical	d										
P.O. Box 68	v requires that the death certificate be executed there is signed by the attending physician and should be detached for use as the burial-transit	Physician/M	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2  No 9 ☐ Unknown  23c. If yes, outcome of 1 ☐ Live Birth 1 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	B	у		23d	I. Date of delive Month	ery Day Year			
	law requires that the nas been signed by the 2 Should be detach	by P	Part II. Other significant conditions contributing to death bu							ne cause of death?			
ds,	quires en sig ould b	ted	End stage chronic obstruc	tive puin	onary dise	ease	1 🗆			bably 4 ☐ Unknown			
COL	law re nas be e 2 sh	Completed					24a. Was auto	DSV	prior to co	psy findings available mpletion of cause of			
æ	sician: The law r certificate has b irector, page 2 s		25. Was case referred to medical			(D. II. (O)		ormed? 2 ANo	1 Yes	2 <b>X</b> lo			
Ita	siciar certif irecto	o Be	examiner?	ent 2 🗆 ER/Outpat	Othe	ace of Death (Checi er: 4 A Nursing Ho		donce 6 $\Box$	Other (Specifi	·)			
<u></u>	g Phy er this ieral d	te: To	27. Manner of Death 28a. Date of injur	y 28b. Time	of 28c. Injury	/ at	28d. Describe I			/			
on	endin eath. or: Aft the fur	fica	2 Accident Investigation		M 1 🗆	Yes 2 No	_						
Division of Vital Records,	al or Att s after d al Direct ed in by l	l Certificate:	4 Homicide determined 28e. Place of Injubuilding, etc	ry - At home, farm, s . <i>(Specify)</i>	street, factory, office		28f. Location ( City or Tov		umber or Rura	Route Number,			
	To the Hospital or Attending Physician: "In thin 24 hours after death. To the Funeral Director. After this certifical completed filled in by the funeral director,	Medical	29a. Certifier (Check only one)  1 X Certifying Physician: To the best of the control of the con	amination and/or inv	estigation, in my opinio	on, death occurred a	t the time, date	and place, an-	d due to the ca	use(s) and manner stated.			
	To the To the Conf.		29b. Signature and title of certifier		29c. License				igned (Month,				
			phly plan	r MD	D5105	51		Nover	mber 2,	2010			
D			30. Name and address of person who completed cause of de			City MD	21042						
	Sta	te	31. Date filed (Month, Day, Year) 32. Registra		Ellicott	CICY, MID	21042						
	Registr	ar	NOV 0 3 2010 Kan	our B.	faces								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Ye ar **Physician** 7.50 AM October 2010 Wallace R. Snyder /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner altimor · Henes Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Days Months Hours Min. 347-24-1903 1 MM 2 □ F 80 8/28/30 Illnois Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 No Director Baltimore Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21229 Funeral 5008 Edmondson Ave 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: 1948— Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: þ 3 Widowed 4 Divorced White 1948-52 Completed 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within th and Mental Hygiene. 7 is marked other than College (1-4or 5+) Elementary/Secondary (0-12) Real Estate Mortgage Banker 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carrie Chamness Wallace P. Snyder injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau 5008 Edmondson Ave. Baltimore, Maryland 21229 Wife Mrs. Louise Snyder Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 11/1/10 Baltimore Crematory 21. Signature of Funeral Service Lice 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 Approximate Interval Between Onset and Death mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line day Immediate Cause (Final **Physician** disease or condition resulting in death) Obstructive 0 /Medical Due to (or as a consequence of): Examiner Meta 3 cuin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-trans Snyder, Wallac Due to (or as a consequence of): cate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23d. Date of delivery yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? bstructire 24a. Was an autopsy performe 1 ☐ Yes 2 No 1 ☐ Yes 2 🗆 No NECK Can Head and **Division of Vital** 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death (Month, Day, Year) 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide Hospital or 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD October 30 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Agree Hospital 900 Conton Avenue . Mitikin, St. 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

NOV 0 3 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Honth Ctober Physician/ 2010 erma Medical give street and number) 4b. City, Toyo, or Location of Death acility Name (if not instituti **Examiner** TIMORE G Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 03/18/192 If Under 1 Year If Under 24 Hrs. last birthday) Social Security Number **Funeral** 1 X M 2 □ F Months Hours Yrs 89 217-18-6372 **Director** Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10a. State 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 X No BALTIMORE BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 4204 OLD MILFORD ROAD 21208 Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🕅 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: WHITE 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) NIGHT CLUB OWNER **OPERATOR** Be traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) r and Mental F မ FREEDMAN SILVERMAN ROSE JULIUS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3420 GARRISON FARMS ROAD, BALTIMORE, MD 21208 Health tem 27 HOWARD KLEIN / BROTHER-IN-LAW 20b. Place of Disposition (Name of MIKeRoletens, Creminator) or other place) 20c. Location - City or Town, State 20a, Method of Disposition Department of Important; If it any injury or o 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State BETH ISRAEL CONG. 11/1/2010 BALTIMORE, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral-Service Licenson 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Scott 11 with 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to ( r as a consequence of) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 - Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death?
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To the Funeral Director: After this certifica completed filled in by the funeral director, I 26. Place of Death (Check only one) 25. Was case referred to medical Certificate: To Be examiner? Hospital 1 Tes 2 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural
Accident
Suicide (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Sign and title of certi old Court Road address of person who completed cause of death (Item 23a) (Type, Print) How 31. Date filed (Month, Day, Year) State 0 3 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ 5:15 PM RITA SAPPERSTEIN October 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** N/A UNION MEMORIAL HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs Social Security Number . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours 11/25/1928 Country) 214-24-2323 81 MD Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Director 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland 1x Yes 2 ☐ No MD N/A BALTIMORE 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral 6711 PARK HEIGHTS AVENUE, L5 21215 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 9 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔽 No Specify: If Yes Give Specify: Completed 3 X Widowed 4 ☐ Divorced WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed. (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) TEACHER EDUCATION Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other transmitted. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ MAURICE MOGOL **REBA** LEBOWITZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THEODORE SAPPERSTEIN/SON 405 OLD CROSSING DRIVE, BALTIMORE, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 1 XBurial 2 Cremation 3 Removal from State 20c. Location - City or Town, State cemetery, crematory or other plac ANSHE EMUNAH AITZ CHAIM CEMETERY Donation 5 Other (Specify) 10/31/2010 BALTIMORE, MD Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, 21208 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ A cute Medical resulting in death) Due to (or as a consequence of) Examiner Coroney Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours affer death.
• Funeral Director: After this certificate has been signed by the attending physician and eled filled in by the funeral director, page 2 should be detached for use as the burial-transit eled filled in by the funeral director, page 2 should be detached for use as the burial-transit Congestive that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Year Pregnant at time of death Yes 2 No 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 2 No 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Be Hospital 2 14 No 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 은 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes Certificate; 28b. Time of 28d. Describe how injury occurred iniury Natural 5 Pending 2 🗌 No 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🖂 To the within 2 To the F only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) AT 2438946

State Registrar

DHMH 17 Rev 7/2009

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32. Registrar's Sigr

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Glister,

0320

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 30,2010 ear Leo Bernard Swinderman 7:00 A. M Physician/ Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Baltimore County Lutherville College Manor Assisted Living 8. Date of Birth (Month, Pay, Year) Dec. 19, 1921 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 5. Social Security Number Sex 1 M 2 □ F 7. Age (In yrs. last birthday) Baltimore, MD. **Funeral** Months Days Hours 88 217-16-5775 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be approximated. 10b. County Director 1 Yes 2 No Baltimore County Lutherville Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States Funeral 21093 1823 Blakefield Circle 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black, White, etc. Armed Forces?

1 Yes 2 If Yes, Give <sup>2 □ No</sup>W.W.II 1 Never Married 2 Married White Completed by 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Midowed 4 Divorced Year or Dates 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Exxon Corp. C.E.O. 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Florence Miller Carroll Swinderman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Cockeysville, MD. 21030 1 Jules Brentony Court Mr. Charles Shaw, Jr. (Per. Rep.) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State (Harford Co.) 20b. Place of Disposition (Name of emeter, crematory or other place)
Evans Funeral Chapel and
Cranation Services, Inc. Monday, Nov.01,2010 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Feografia Alternatives Funeral & Cremation Center, P.A.
2325 York Road Timonium, Maryland 21093—2215 21. Signature of Funeral Service Licensee Jeffrey L. Gair, Sr. aur 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death denentia Immediate Cause (Final carl duAnce Pnysician, disease or condition resulting in death) Due to (or as a consequence of) Medical Examiner Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury The law requires that the death certificate be executed physician and the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery asn 23b. Was decedent pregnant Year Month Day in the past 12 months? detached for Pregnant at time of death 2 No the 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 2 → No 3 → Probably 4 → Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a Was an autopsy performed? Yes 2 has death? 2 🗆 No 1 🗌 Yes 26. Place of Death (Check only one) 6 Other (Specify) Assisted 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 2 - No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes ပ this 28b. Time of 28c. Injury at 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: iniury Director: After Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 6 Could not be hours after Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 24 hours Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) To the within 70 the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier November 1, 2010 Type. Print) M- Charles St. Balks. md 20204 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BINC 32. Registrar State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October Physician/ 2010 11:35 P.M Anna A. Stevens Medical 4c. County of Death
Baltimore 4b. City, Town, or Location of Death TOWSON 4a. Facility Name (if not institution, give street and number) Examiner Gilchrist Hospice 8. Date of Birth (Month, Day, Year) May 22, 1921 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Months Days Hours Min Balt. Maryland 216-18-4376 89 Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland aţ Director r 28a-f s notified Timonium Maryland Baltimore 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code ö 10g Citizen of What Country? United States must be r Funeral 21093 206 Patann Road of America items 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, "natural", or item edical Examiner n 11. Marital Status Armed Forces? Black, White, etc. ğ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after white 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 Divorced 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Home maker Own Home Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important; If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Goldie Easley ည Wilton Allen spouse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samuel Edward Stevens, Jr./ 206 Patann Road Timonium, Maryland 21093 20a. Method of Disposition 20b. Place of Disposition (Name of November 20c Location - City or Town, State Evanster Funeral other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 Forest Hill, Maryland Chapel-Bel Air Signatu ral Service Licens 22. Name and Address of Facility P.A. Peaceful Alternatives Funeral and Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PANCIECTR disease or condition Medical resulting in death) ue to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23h Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No for Month Dav Year Pregnant at time of death the detached g Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No page certificate 1 🗌 Yes 2 🗌 No Yes 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) Hospital 2 No Other: 4 Nursing Home 5 Residence 6 D Other (Specify) 1 Tyes ပ္ 1 Inpatient 2 ER/Outpatient 3 IDOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🕍 Natural 5  $\square$  Pending injury s after death. 1 🗌 Yes 2 🔲 No Investigation 6 Could not be Accident the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one ertifier 29b. Signature a 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Chores ST Towson MO 670 Amon VER  $\sim$ 

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene U | U For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 29, 2010 Physician/ Marya T. Strong 7:00 P. M October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Baltimore County **Examiner** Timonium Stella Maris Nursing Home 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🗶 F Months Days Hours Min Jan. 10, 1921 89 Baltimore, MD. 521-30-9472 **Director** Usual Residence of Decedent 28a-f show 10b County 10c. City. Town or Location 10a. State 10d. Inside City Limits Director notified 1 X Yes 2 No N/A Baltimore Maryland 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country must be 21212 United States 23a Funeral 317 Homeland Southway 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Black, White, etc. 0 þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. White Specify. "natural" 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 02 Own Home Home Maker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kathryn Strong John Tregellas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important; If item 27 is any injury or other trat 10701 Anglo Hill Road Cockeysville, MD. 21030-2935 Mr. Lloyd Tinker (Son) 20c. Location - City or Town, State (Harford Co.) 20a. Method of Disposition 20b. Place of Disposition (Name of Evans Furerall Chareful and Cremation Services Inc. 1 Burial 2 Cremation 3 Removal from State Monday Nov.01,2010 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland Gair, Sr. Peaceful Afternatives Funeral & Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093-2215 21. Signature of Funeral Service Licensee Jeffrey L. Cai:

Johnson J. Jan. 2 Lic.#M00677 2325 York Road Timonium, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and eath Immediate Cause (Final Ph sician/ ongestive disease or condition resulting in death) 01 160.0 Medical Due to (or as a lonsequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Box in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death 5 Other (specify) Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law has autopsv performed? 1 ☐ Yes 2 No Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 **2** No Hospital: Other: 1 🗌 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Division of 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No 1-Natural Within 24 hours after according to the Funeral Director; Af М 3 | Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of cer 29c. License number 29d. Date signed (Mouth, Day, Year) 245 910 U Vember we 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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2300 DULANEY VALLEY ROAD

TIMONIUM, MD 21093

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lliam Charles	Spi	inks State of Maryland / Department o	f Health and Mental Hy		10 34322
Physici edical Exami		Decedent's Name (First, Middle,Last)     WILLIAM CHARLES SPINKS	4b. City, Town, or Location of Death	2. Date of Death Month Day Year October 25, 2010  4c. County of	3. Time of Death 0657 hrs
Funeral Director		1927 E. Lafayette Avenue  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)  220-06-3019  7. Age (In yrs. last birthday)	Baltimore  If Under 1 Year   If Under 24Hrs.  Months   Days   Hours   Min.	N/. 8. Date of Birth (MM/DD/YYYY)	A
uh with the Maryland tems 23a or 28a-f show any st he notified at once.	Funeral Director	1 X Never Married 2 Married Armed Forces?			10d. Inside City Limits 1 X Yes 2 No t Country?  American Indian, Black,
; MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland calls and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she trammatic event, the Medical Examiner must be notified at once	Completed by Fun	3 Widowed 4 Divorced of Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	Yes 2 No specify:  nt's Usual Occupation (Give kind of working life. DO NOT use retired to the specific of the	specify: Specify: Nork done ed) 16b. Kind of Busin	WHITE ness/Industry
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within Department of Health and Mernal Hygiene. Important: If item 27 is marked other than injury or other tranmatic event, the Medic.	To Be C	WILLIAM LEE SPINKS  19a. Informant's Name/Relationship (Type, Print)  CONSTANCE ARENAS (MOTHER)  20a. Method of Disposition  Burial 2 X Cremation 3 Removal from State  Donation 5 Other Specify:  METRO CRE  21. Signature of Funeral State Licenses I ONATIAN D. HIBN 22 N	CONST. g Address (Street and Number or R 29 E. LAFAYETTE A sition (Name of cemetery, her place) CMATORY 11— Name and Address of Facility PHT	VE. BALTIMORE, Date 20c. Location - C 20-2010 BALTIMORE LLIPS FUNERAL HO	MARYLAND 21213 ity or Town, State  RE, MARYLAND  OME, P.A.
Physician M. cical xaminer	ner	23a. Fant . Enter the disease, or complications that caused the death. Do not enter the fature. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause.		respiratory arrest, shock, or heart	Approximate Interval Between Onset and Death
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit	an/Medical Examine	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.  X UNPENDED  AMENDED  23a, 27, 28a-f, per  23b. Was decedent pregnant in the	ME g909 11/5/10	23d. Date of de	livery Day Year
P.O.	2	Program at time of death	her (Specify)		te to the cause of death?  Probably 4 Unknown
ital Records, ician: The law requir s certificate has been s rector, page 2 should l	Be Completed	25. Was case referred to medical examiner? Hospital: I location 2 FR/Outpotical	26.Place of Death (Check o	autopsy pric dee 1	re autopsy findings available of the completion of cause of the completion of cause of the completion
Division of Vital Records, To the Hospital or Attending Physician: The law require within 24 hours after death. To the Funeral Director: After this certificate has been st completely filled in by the funeral director, page 2 should	ertification: To	27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide  Natural 1 Natural 2 Pending Investigation 3 Suicide 4 Natural 4 Natural 5 Pending Investigation 6 Could not be determined 6 (Specify)  1 Inpatient 2 ER/Outpatient 2 28b. Time of Injury (Month, Day, Year) 28b. Place of Injury - At home, farm, street (Specify)	njury 28c. Injury at Work?  1 Yes 2 No	n Home 5 Residence 6 22 28d. Describe how injury occurred in k 28f. Location (Street and Number of Town, State) 1927 E	
To the Hosp within 24 hos To the Fune completely fi	edical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occur (Check only one) 2 Medical Examiner: On the basis of examination and/or investigat and manner stated.  29b. Signature and title of certifier	red at the time, date and place, and o	due to the cause(s) and manner as the time, date and place, and due 29d. Date signed	s stated. to the cause(s) (Month, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn S		October 25, 2	

DHMH 17 Rev 1/2001 OCME 2006

Registrar

State 31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ atherine 165R Medical 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hospita more 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 Hours Min. F6 25, 192 Yrs. Director mary land or 28a-f show 10a, State 10b. County be filed within 72 hours after death with the Maryland 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at **Funeral Director** 10d. Inside City Limits Massland 1X Yes 2 No im ore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a United State 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ò Completed by 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. 2 1 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", 3 Widowed 4 Divorced Black Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o permit. Page 1 and 2 should be Department of Health and Menta Important. If item 27 is marked any injury or con-ည awrence 6 cours 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Khdil Baltomore 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility

Aug 4. Will Na. 200 Signature of Funeral Service Licenses F.S.P.A alum 1 a 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition Vasc Medical resulting in death) Examiner Due to (or s a consequence of Seque tially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): To the Hospital or Attending Physician; The law requires that the death certificate be executed LINKNOWN attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 menths?
1 ☐ Yes 2 ☑ No Pregnant at time of death Month Day Year ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No certificate 2 🗆 No 1 Yes Be 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: 욘 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify After this 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 5 Pending Accident Investigation Suicide 6 🗆 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number ☐ Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse(Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29b. Signature and title of certifier 29c. License number AT2438944-C24

Registrar DHMH 17 Rev 7/2009

State

acke

Vaillant, MI

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) NOV 0 3 2010

31

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Rebecca Ann Salvo 2010 34324 State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 3. Time of Death Month Day October 31, 2010 Medical Examiner 0239 hrs Rebecca Ann Salvo

4a. Facility Name (if not institution, give street and number) Rebecca 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Rel Air Harford 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Director 220-21-3095 Hours 1 M 2X F 22 Country) Maryland May 8, 1988 Usual Residence of Decedent iny 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 X No imore, MD 21215-0036
Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

tant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once, Maryland Harford Street Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 1295 Macton Road 21154 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-14. Race - American Indian, Black, 1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Yes Specify: White 4 Divorced 1 Yes 2 No specify: f Yes, Give Year <u></u> 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+ Full Time Student 4 Education 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Mr. Gary S. Salvo Mrs. Kathy L. Salvo (nee Lawson) 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Gary S. Salvo (Father) 1295 Macton Rd. Street, MD 21154 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Itimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State November 4 Bel Air Mem. Grnds 2010 4 Donation 5 Other Specify. Bel Air, Maryland Signature of Funeral Service Licensee 22 Name and Address of Facility Evans Funeral Chapel & Cremation Services - 1 3 Newport Drive, Forest Hill, Maryland 21050 Jeffrey R. Prilleman (MO1543) Testerman 216. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Methadone intoxication Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examine cause: Enter Underlying Cause. (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and tran Physician/Medical g physician a X UNPENDED AMENDED 27,28a-f,per ME g909 11/18/10 TT Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery attending p 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✔ Unknown signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed has been s 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? page certificate 1 🗸 Yes ✓ Yes 2 No 2 No 25. Was case referred to medical Hospital or Attending Physician: funeral director, 26.Place of Death (Check only one) Be Other<sub>4</sub> Hospital: 1 ✓ Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: this 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Fd 10/30/10 Fd 11:56 am <sup>1</sup> Yes 2 No Natural unk neral Director: / 5 Pending hours after death. Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3905 Salem Church Rojarrettsville, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc Suicide 6 X Could not be fo the within 24 hour.
The Funeral F determined (Specify) found in house Homicide To the Func completely f 29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 31, 2010 30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature

**ORIGINAL** 

DHMH 17 Rev 1/2001 **OCME 2006** 

State

Registrar

2010

MOV 03

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician/ homp son eather Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Regional Hospita -aure durel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕅 F 84 Months Days Hours Min. Director 205-20-1748 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10c. City, Town or Location 10b. County 10a. State Director Laurel Prince George's Maryland 10f. Zip Code 10e. Street and Number Funeral 9010 Briarcroft Lane #113B 20708 2 should be filed within 72 hours after death the and Mental Hygiene. 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. 3 ¥ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Teacher's Aide Be 17. Father's Name (First, Middle, Last) ပ Julia Newkirk William L. Bannerman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8306 Maple Street, Laurel, Maryland 20707 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health al Important: If item 27 is any injury or other trau Denise A. Spriggs - Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore Washington Crem, 11/02/2010 4 Donation 5 Other (Specify) 22. Name and Address of Facility Fleck Funeral Home, Inc. Signature of Funeral Service Lic MO1283 se, or complications that caused 23a. Part 1. Enter the dise shock, or heart failure eed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, kist only one cause on Immediate Cause (Final disease or condition resulting in death) Sepsis Physician/ Medical Due to (or as a consequence of) Examiner Pneumonid Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown this certificate has been signed by the atteral director, page 2 should be detached for 4 Pregnant at time of death
9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Acute Renal Failure Division of Vital Records, Myocardial Infarction To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29c. License number 29b. Signature and title of D55861

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD,

Munim.

Laurel

32 Registrate Signatura &

10d. Inside City Limits 1 🗆 Yes 2 ី No 10g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc Black 16b. Kind of Business Industry Education 18. Mother's Name (First, Middle, Maiden Surname) 20c. Location - City or Town, State Laurel, Maryland 7601 Sandy Spring Road, Laurel, Maryland 20707 Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2010 October 31, 7300 Van Dusen Road MD

Reg. No.

4c. County of Death

Prince

3. Time of Death

George's

9. Birthplace (State or Foreign

North Carolina

4:55 AM

2. Date of Death

8. Date of Birth

Aug.

(Month, Day,

October

Registrar

DHMH 17 Rev 7/2009

State

Regional Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #7, per Fh G908 11/3/10 TT 19a
State of Maryland / Department of Health and Mental Hygiene
amend #19a Per INF G910 12/02/10 JH

Certificate of Death For State Registrar Reg. No.-cedent's Name (First, Middle, L<del>as</del> 2. Date of Death 3. Time of Death Physician/ 337 AM Medical Facility Name (if not institution, give street and number) **Examiner** 4b. City Town, or Location of Death 4c. County of Death 1410 Social Security Number 218-42-4424 Jast birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 9. Birthplace (State or Foreign Country) MD 1 X M 2 □ F Months Days Min. (Month, Day, Year, 11/1/17/44 65Yrs. Hours Director Usual Residence of Decedent 28a-f shov 10c. City, Town or Location
Baltimore City permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if frem 27 is an arked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10b. County 10a. State 10d. Inside City Limits Funeral Director N/A MD 1 🖺 Yes 2 🗌 No 10e. Street and Number 1209 Scott Street 10f. Zip Code 10g. Citizen of What Country? 21230 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Armed Force Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 white 1 Yes 2 XX Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Mechanic Manufacturing 11 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Margie H. Nelson Erman H. Turner 2 19a. Info**dreacy** L. Buzzell / 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 113 Holly Ridge Dr., Bluffton SC 29910 Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot once. Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Crestlawn Cemetery 11/3/2010 Marriottsville, MD 4 Donation 5 Other (Specify) Doda, J. 22. Name and Address of Facility
Charles I. Stevens Funeral Home Inc.
1501 E. Fort Avenue, Baltimore MD 21230 21. Signature of Funeral Service Licensee Victor P. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Onset and Death Physician/ Tension
Due to (or as a consec Pneumothorax disease or condition Medical resulting in death) to (or as a consequence of) Examiner obstructive pulmonary LYOHIC Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): sician and burial-transit Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 1 Yes 2 No neral Director: After this certificate has been signed by the filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Mesothelioma 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 N prior to completion of cause of death? 1 Yes 25. Was case referred to medical examiner?

1. Yes 2 \sum No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No ne Hospital or Attending Plin 24 hours after death. Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide injury 5 Pendina M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated — Gertifying Nurse Practicines. To the cost of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the I or ly-or el 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 19735 Oct. 29, 2010 Junt 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cobert 22 South Greene Street, Baltimore, MD 2/201 32. Pegistrar's Signature 31. Date filed (Month, Day, Year) State 2010 escus. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month IO 27 20To Cathare Noble Thompson 8:18p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death <u>Sinai Hospital</u> Baltimore 7. Age (In yrs. last birthday) **Funeral** Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 1 M 2 F Months Days Hours Min (Month, Day, Year) Director 234-30-5869 86 20 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 10d. Inside City Limits MD NA Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3501 Howard Park Ave #119 21207 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 ☐ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 12th grade College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the I once. Administrator Post Office Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nathaniel Noble Sr. <u>Ellawease Shade</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Salimah Shabazz-Daughter 303 Highland Drive, Baltimore, Md 21239 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill 11/3/2010 Baltimore, Md Signature of Funeral Service Licens 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Cardioresperatory Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner myocardial Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Cornary artery the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Day Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Hemalietia, Hyperly ma Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed?

1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Lecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my learning the place of the cause(s) and manner stated. (Check Certifying Nurse Practioner est of my knowledge. Shath occurred at the time, date and place, and due to the caucale) and mainter as stated 29b. Signature and title of certifier 016189 Kurliar mo pr 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Charles St \$14202 TOWSON ND 21200 FORLE NIKARKAR MODA 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Ctober Day **Physician** 31,2010 ula MOR /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Arnold future Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth **Funeral** Hours Days 1 □ M 2 🕱 F Months Min. 08/30/1919 91 218-01-7751 Yrs Baltimore, MD Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☑ No Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21204 U.S.A. 305 E. Joppa Road Apt. 2104 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore. Maryland 21215-0036 1 ☐Yes 2 🛣 No Specify: Specify: White ģ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Edward A. Hanft Nettie A. Armiger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marion J. Gunther/ daughter 2009 Harbour Gate Drive #144, Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If it any Injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 11/03/2010 | Ellicott City, MD St. John's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Towson, ML, 21204 21. Signature of Funeral Service Licensee 1 elistri amy Ruck Towson Funeral Home, Inc. 1050 York Rd. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** YOCARDIAL INFARCTION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year ☐ Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No No 1 ☐ Yes 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of eath Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one)

Records, Division of Vital within 24 hours after deatl

To the Funeral Director; Hospital completely

> State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day,

NOV 0 3 2010

Ne

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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DHMH 17 Rev 1/2001

Velerans

32. Registrar's Signature

29c. License number

29d, Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ October 27, 2010 8:55 p.M Taylor Buelah Lynda Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Co. Severna Park 826 Dividing Road If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** 1 □ M 2 🗓 F Hours Country) 0372171947 MD 63 **Director** 214-48-1050 Usual Residence of Decedent show 10d. Inside City Limits and Mental Hygiene. 'is marked other than "natural", or items 23a or 28a-f shov raumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. In the Maryland fitem 27 is marked other than "natural", or items 23a or 28a-f shouny or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 1 Tes 2 T No Anne Arundel Co. Severna Park MD 10f. Zip Code 10a. Citizen of What Country? 10e. Street and Numbe Completed by Funeral United States 21146 826 Dividing Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S. 11, Marital Status Armed Force Black, White, etc. 1 Never Married 2 X Married ☐ Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2X No Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Publishing Writer vr Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Janey Lavinia Wood Cyril Patrick Bohle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 826 Dividing Road Severna Park, MD Wade Taylor, Jr./Husband Α. Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a Department of H Important: If ite any injury or ot cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 11/03/2010 Glen Burnie, Maryland Glen Haven Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation Signature of Funeral Ser Service PA; 1 2nd Ave SW, Glen Burnie, MD 21061 M01121 23a. Part 1. Enter the disease, or complications sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one duse on each line. Interval Between Onset and Death Immediate Cause (Final mons Pnysician disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Imjury Examine Due to (or as a consequence of) for use as the burial-transi that initiated events physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Year Pregnant at time of death Yes 2 NO 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. \$ 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Tes 26. Place of Death (Check only one) Be 25. Was case referred to medica examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending M Investigation Accident Suicide ☐ Acciue,.. ☐ Suicide ☐ Homicide

To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the bur

Certificate:

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: To the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) of certifie 29b. Signature D0043375 28 2010

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Location (Street and Number or Rural Route Number, City or Town, State)

State

Medical

31. Date filed (Month, Day, Year) NOV 03

30. Name and a

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2010

determined

2. Registrar's Signature

2835

who completed cause of death (Item 23a) (Type, Print)

acke

Registrar

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ famison Summer Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore n/a If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days (Month, Day, Year) Hours Min. 83 Yrs. 218-22-6987 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland "natural", or items 23a or 28a-f sho Director M) n/a Baltimore 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3203 Elgin Avenue 21216 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: any ijury or other traumatic event, the Medical Examiner mus once. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☑ Yes 2 ☐ No Black, White, etc ğ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: African-American 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 11th Steel Worker Bethlehan Steel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles D. Taylor Florence Bagwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tanya Mims/ Daughter 10565 Wren Ridge Road. Alphametta GA 30022 20a. Method of Disposition Entanbant
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arbutus Memorial Park Date 20c. Location - City or Town, State ☐ Donation 5 🛛 Other (Specify) 11-6-2010 Arbutus, MD 22. Name and Address of Facility Wile Funeral Time P.A. of Signatur of Funeral Service Licensee 0 9200 Liberty Road, Randallstown, MD 21133 Part I. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a heart failure. List only one cause on each line. Approximate Interval Between Ons. t. nd Death Immedia Physician arcinoma 0 disease or condition resulting in death) 2107202 Medical Due to (or as a consequence of): Examiner Sequentially flat conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Vear Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 📝 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🛮 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending ours after death.

neral Director; Af
filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide 24 hours a Funeral I Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and tide of certifie 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Boularard Tack 3900 Loci 31. Date filed (Month, Day, Year)
NOV 0 3 2010 32. Registra 's Signature State

DHMH 17 Rev 7/2009

Registrar

NOV 03

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October Physician/ 2010 рм 12:30 Gary James Turnbull Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George 14945 Belle Ami Drive Laurel Birthplace (State or Foreign Country)
 N T If Under 1 Year 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number 6, Sex **Funeral** Min. 1 🔀 M 2 🗆 F Months Days Hours sept 1 NJ 63 Director 563-68-1708 Usual Residence of Decedent 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County with the Maryland Director 1 Yes 2 No Laurel Prince George MD 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Numbe Funeral USA 20707 14945 Belle Ami Drive 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after death 14. Race - American Indian, 11. Marital Status Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Specify: white 3**XX**Widowed 4 □ Divorced Completed Year or Dates. 1971-74 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) National Security College (1-4 or 5+) Elementary/Seconday (0-12) Linguist Agency Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic even ည Monica Ann McCoy Charles Robert Turnbull 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 217 Windsong Drive, Henderson, NV 89074 Monica Gallagher / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Nov. Date 3 20a. Method of Disposition 1 Durial 2 Cremation 3XRemoval from State 2010 Anaheim Cemetery Anaheim Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Donaldson Funeral Home, P.A. Signature of Funeral Service Licensee 313 Talbott Ave., Laurel, MD 20707 M01053 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final enysician/ Atherosclerotic cardiovascular disease 10 years disease or condition resulting in death) ✓ Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and as been signed by the attending physician and 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Year in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death Unknown P.O. I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Major depression Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2**XX**No Yes 2 X No 1 🗌 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 1 Tes 4 Nursing Home 5xxResidence 6 Other (Specify) 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA ျ 28b. Time of 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d, Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in by determined within 24 hours a

To the Funeral D

completed filled i Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number November 2,2010 D43237 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14201 Laurel Park Drive, Suite 102, Laurel, MD 20707 Paul Armstrong, MD,

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 23:55 PM Octobe 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Franklin Square 5. Social Security Number 6 Hospital Center 8. Date of Birth (Month, Day If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign . Age (In yrs. last birthday) **Funeral** Days 213-52-0564 1 ☐ M 2 🗆 F Marylar Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinat must be notified at Maryland 1 ☑Yes 2 ☐ No Director 10g. Citizen of What Country? 10e. Street and Number Funeral 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ Yo 1 □Yes 2 If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Completed by 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Verizon ustomer Service Represente Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Richard Lance ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Tuck-husba, 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner schemic colitis Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed lostridium ed by the attending physician and detached for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Dav Year 5 Other (specify) ☐Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐Yes 2 ☐ No this certificate 1 ☐ Yes 2 X No Division of Vital director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 XNo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and tifle of certifier OCTOBER 29,2010 the Houtel M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1, M.D. 9000 Franklin Square Drive Baltimore, MO 21237 Kottarathil

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiepe 1 - For State Registrar Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician October 27, 4:00 PM 2010 Tien Duc Trinh /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Montgomery 10945 Broad Green Terrace Potomac If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year North) | 1 Hours | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 Hours | 26, | 1 H 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year Months 1**X**M 2□ F 88 Yrs. 1922 Vietnam 217-86-4619 Director Usuat Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City. Town or Location item 27 is marked other than "natural", or iteme 23a or 28a-f ehow other traumatic event, the Modical Examinar must be notified at 10a. State 1 Yes 2X No Potomac Montgomery Maryland Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20854 United States 10945 Broad Green Terrace Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. e filed within 72 hours after I Hygiene. other than "natural", or ite 1 Never Married 2 Married 0.0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Asian þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Textile Import-Export 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be innent of Health and Mental Isant: If item 27 is marked of Vu Lien Duc Trinh Huu 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10945 Broad Green Terrace, Potomac, Maryland 20854 Quan Trinh / Son 20b. Place of Disposition (Name of Cometery, crematory or other place) 20c. Location - City or Town, State October 29 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department of Important: If it any injury or conce. Bethesda, Maryland 4 □Donation 5 □Other (Specify) Cremătorium, Inc. 2010 21. Signature of Funeral Service Licensee RODERT A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 ette Smals M01305 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Liver Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-transit certificate be executed Exam Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death signed by the at d be detached fo 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2X No has 1 Tes or Attending Physician: 25. Was case reterred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 🕅 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2X No ို 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 ⚠Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how intury occurred 28b. Time of Certification: After 5 Pending after death.

Director: Aft of in by the fur investigation м 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D37412 October 28, 2010 f person who completed cause of death (Item 23a) (Type, Print) 30. Name and address 1355 Piccard Drive, Suite 100, Rockville, Maryland 20850 Geoffrey Coleman, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OCTOBER 20 10 10:36P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7906 HUMBOLDT ROAD BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** Days Months Min. 1 M 2 XF Hours **Director** 213-09-4735 93 04/04/1917 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director **BALTIMORE** 1 Yes 2/1 No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7906 HUMBOLDT ROAD 21208 USA hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Was Deceue...
Armed Forces?

1 Yes 2 No 14 Race - American Indian. Black, White, etc. þ 1 Never Married 2 M Married Maryland 21215-0036 1 ☐ Yes 2 💢 No WHITE Specify 3 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER and Mental Hygie is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ **JACOB** ZIPER MINNIE ZEMIL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 ALVIN TAMRES/HUSBAND 7906 HUMBOLDT ROAD, BALTIMORE 21208 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State any injury or BETH TFILOH CEMETERY 11/01/2010 4 Donation 5 Other (Specify) BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Examiner mer 20 years Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examil the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi that initiated events resulting in death) Last nding physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 1 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed page 2 2 0 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Yes 2 V No မ 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident Suicide 1 Yes 2 🗌 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated who completed cause of death (Item 23a) (Type, Print) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [ ] For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Oct Enth 2010 30<sup>9</sup> 9:47  $A_M$ Patricia Ann Unger Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Carroll Sykesville 5841 White Rock Rd. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD 8. Date of Birth **Funeral** Age (In yrs. last birthday) 1 □ M 2 🛣 F April Day Ye Year) 1933 77 Days Hours Min 217-28-9534 Director Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Sykesville MD Carroll 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21784 United States 5841 White Rock Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🔀 No Specify: Specify: "natural". 3X Widowed 4 □ Divorced Completed Year or Dates Page 1 and 2 should be filed within 72 hour: ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natu. ury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired)

Telephone Operator (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Chesapeake & Potomac 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, မ J. Francis Comer Edna May Hinkle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2203 Dulaney Terrace Westminster, MD 21157 Betty Williams (Granddaughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or Carroll Crematory 11/1/2010 Winfield, MD 4 ☐ Donation 5 ☐ Other (Specify) Surrier-Queen Funeral Home and Crematory, 1212 W. Old Liberty Rd. Winfield, MD 21784 Signature of Eur 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. colon ca Immediate Cause (Final th na atheris Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to or as a consequence of cause. Enter Underlying the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: for use yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performe this certificate 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 2 No 1 Tes ျဉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Other (Specify) Hospice Manger of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature nd title of certifier ned (Month, Day, Year) 10 D0004 CLA ss of person who completed cause of death (Item 23a) (Type, Print) H . D. liberty SULTU 20 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 12:51PM 2010 ana October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Y Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2🛣 F Months 220-88-5819 49 Germany Director Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10b. County 10c. City. Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Annapolis Anne Arundel MD 1 Yes 2 No 10f. Zip Code 21403 10g. Citizen of What Country? 10e. Street and Number Completed by Funeral 17 Marcs Court, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. 1X Never Married 2 Married Yes 2 X No Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Technician Health Care Telemetry 12 Be 18. Mother's Name (First, Middle, Maiden Surname)
Henriette Suc 17. Father's Name (First, Middle, Last) Sucker and Mental h ည Burnell VonHendricks Page 1 and 2 should be n. Informant's Name/Relationship (Type, Print)

T'nia VonHendricks/Daughter 17 Marcs Court #C, Annapolis, MD 21403 19a. Informant's Name/Relationship (Type, Print) of Health a Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date Department of H Important: If ite any Injury or oth remetery, crematory or other place)
Final Journey Crem. 1 Burial 2 Cremation 3 Removal from State 11/1/2010 Woodbine, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD Signature of Funeral Service Licensee Dorota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ -urdiaL disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** 0,0 CD Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): 10 andia attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last by Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Vear Month signed by the aid 1 ☐ Yes 2.45 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Certificate: To Be Completed . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗆 Yes 2 No 1 Unpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27. Manner Death 1 Natural 5 Pending 1 Yes 2 No Investigation the Funeral Director: / Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a Certifier ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Regist ar's Signature 31. Date filed (Month, Day, Year) State 10 Registrar

			For State	State of Marylan	-	artment of F			/	010	34337
			Registrar  1. Decedent's Name (First, Middle, Last)		061	incate of L	Catri	2. Date of Dea	Reg. No.		3. Time of Death
	Physicia Medic		Fred Merle Witten					0c tobe	$r 2^{D_4}$	201 <sup>°</sup> 0′	7:30 Am
	Examin		4a. Facility Name (if not institution, give st			4b. City, Town, or	Location of Dea	th		County of Death	was I s
			Heartfields Assist		est hirthday)	Bowie If Under 1 Year	If Under 24 Hr	s. 8. Date of Birl		nce Geo	rge S place (State or Foreign
	Funeral Director		448-26-7034	Хм 2 □ г 79	Yrs.	Months Days	Hours Mir	NOV • 1	6 Year 19	30 Miss	ouri
	, MC		Usual Residence of Decedent  10a. State 10b. County	100 00	v. Town or Lo	antion					0d. Inside City Limits
	ıryland a-f she ied al	Funeral Director			wie	Cation					1 X Yes 2 No
	he Ma or 28a o notii	Dire	Maryland Prince Ge 10e. Street and Number	eorge s   bo	wie	10f. Zip Code			10g. Citiz	zen of What Cour	ntry?
	with t	eral	12500 Rambling Lane	2		20715			USA		
	death items nerm		11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13.	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (	Specify Yes or No- rto Rican, etc.)	1	4. Race - Americ Black, White,	
36	after al", or xami	d by	1 ☐ Never Married 2 ☐ Married 3 ሺ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces?  1		1 □ Yes 2 🛣 No	Specify:		S	Specify: Whit	
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121	d with lygien ther ti nt, the	Be C	17. Father's Name (First, Middle, Last)	1		Engir		ame (First, Middle,	Maidon S		
anc	be file antal H ked o c eve	70 E	Frederick Wesley	Witten				Pearl M			
ary	nould and Ma s mar umati		19a. Informant's Name/Relationship (Typ		19b. Maili	ng Address (Street	and Number or F	Rural Route Numbe	r, City or T	Town, State, Zip	Code)
Σ	nd 2 sl ealth a m 27 i		Randy Witten/ Son			O Rambli	ng Lane				
Baltimore, Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	Place of Dispo cemetery, crea Mayou	osition <i>(Name of</i> matory or other place land	ce)	Date	20c. Lo	cation - City or To	own, State
Him	artmer ortant injury		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Paheral Service Linens		terans	natory or other place  and  cemetery  Name and Addre	ss of Facility	3/2010 ]	Evar	ns Funer	al Home
Ba	permi Depar Impo any ir once.		· LUMT		1	6000 Anna	apolis R	Road Bowi	e, Mi	20715	u i i i i i i i i i i i i i i i i i i i
			23a. Part 1. Enter the disease, or compli shock, or heart failure. List only one	ications that caused the deat e cause on each line.	h. Do not ent	er the mode of dyin	g, such as cardi	ac or respiratory ar	rest,		Approximate Interval Between
	Physician/		Immediate Cause (Final disease or condition	Prostate Ca	ncer						Onset and Death
P-7	Medical Examiner		resulting in death)	Due to (or as a consequence	uence of):						
		ner	if any, leading to immediate	Due to (or as a conseq	uence of):						
	outed nd ransit	Examiner	tildt illitiated evente	o							
	eath certificate be executed attending physician and for use as the burial-transit	al E	resulting in death) Last	Due to (or as a conseq	uence ot):						
68760	physic	edical		d							
89	certifii nding use as	N/M	23b. Was decedent pregnant	3c. If yes, outcome of pregna	ancy	☐ Ectopic pregnan-	CV/		2	23d. Date of deliv	rery
Box	death ne atte ed for	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of 9 Unknown		Other (specify)				Month	Day Year
P.O.	Attending Physician: The law requires that the death certificate be executed or death.  ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Phy	Part II. Other significant conditions cor	ntributing to death but not res	sulting in the	underlying cause gi	ven in Part I.	23e. Did t	obacco us	se contribute to t	he cause of death?
s, P	v requires that s been signed to should be deta	d by						_ 1 🗆	Yes 2	□ No 3 □ Pro	bably 4 🛣 Unknown
ord	v requ	Completed						24a. Was		24b. Were auto	ppsy findings available empletion of cause of
3ec	The law ate has page 2 s	mo							ormed? 2 No		
E	sician: The certificate rector, pag	Be	25. Was case referred to medical examiner?	lospital:			lace of Death (C/			v	Assisted
Ę	Physic this o	은	1 ☐ Yes 2 X No ☐ 27. Manner of Death	1 Inpatient 2 28a. Date of injury	ER/Outpatie		4 L Nursing	Home 5 Resi			Living -
0 0	nding th. : After s funer	cate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	wor	k? Yes 2 □ No	200. 200020	now injury	00041100	
Division of Vital Records,	Atter er dea ector by the	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, st	reet, factory, office		28f. Location (		Number or Rura	l Route Number,
Ω̈́	To the Hospital or Attending Physician: The Is within 24 hours after death.  To the Funeral Director: After this certificate ha completed filled in by the funeral director, page	a C	¥				- data			d manney 5 - 54-1	nd.
	Hosp 24 hou Fune eted fil	Medical	(Chook 2 Medical Evamin	cian: To the best of my know er: On the basis of examination e Practioner: To the best of m	on and/or inves	stigation in my opini	on, death occurre	ed at the time, date	and place.	and due to the ca	ause(s) and manner stated.
	Fo the within Fo the comple	Σ	only one) 3 L Certifying Nurse  29b. Signature and title of certifier	Fractioner: To the pest of fr	iy kilowieuge,	29c. Licens		p. 200, and 000 to ti		e signed (Month,	
	- > - 0		man C	rella		D2374	3		10/2	5/2010	
, ,	~\		30. Name and address of person who co	empleted cause of death (Iter	n 23a) (Type,	Print)					
To	7 '		Martin Weltz, M.D  31. Date filed (Month, Day, Year)	., 7525 Green	iway Ce	enter Dri	ve Greer	nbelt, MD	207	/0	
	Sta		31. Date filed (Month, Day, Year)	Je segistrary signa	XIF CALL						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 8:34 AM Medical 4a. Facility Name (if not institution, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hlenda Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Country) M 2 🗆 F Months Hours Min Director Usual Residence of Decedent Show 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland : If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Completed by Funeral Director 10d. Inside City Limits 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2122 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 M No Specify: 3 ₩idowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filled within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumetr. life. DO NOT use retired, Elementary/Seconday (0-12) College (1-4 or 5+) Be Father's Name (First, Middle, Last) မ 19a. Informant's Name/Relationship (Type, P 19b. Mailing Address (Street and Number or Rural, Route Number, Allenda Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemulary, crematory or other place) - City or Town, State ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) re of Funeral Service Licens anda 23a. Part 1. Erte the disease, or complications that caused shock, or beart failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final (suspected Ph<sub>sician/</sub> ong disease or condition resulting in death) es Medical Due to (or as ac insequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): 124 hours after death. e Funeral Director. After this certificate has been signed by the attending physician ≀ Inhard filled in by the funeral director, page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year 1 ☐ Yes 2 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 2 🗌 No 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title of 29d. Datę signed (Month, Day, Year) 3 30. Name and add of person who completed cause of death (Item 23a) (Type, Print) B Ba 21244 timore MU

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

32. Registrar Signat

Alan Zackery Charis Williams Ja Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unk Unk 1-For State Amend Items of Maryland / Department of Health and Mental Hygiens Certificate of Death Rea No 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Alan Zackery Williams, Medical Examiner Jr. Month 0259 hrs October 26, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Sinai Hospital Baltimore N/A Social Security Number 104-82-4442 6. Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Director Months Davs Hours 16 1 X M 2 F 2/3/1994 NY Yrs Usual Residence of Decedent any 10a. State 10c. City, Town or Location 10d. Inside City Limits MD n/a Show Baltimore City 1 XXYes 2 No hours after death with the Maryland Directo 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 3437 Paton Avenue P.H. 21215 usa Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 1 Never Married 2 Married Armed Forces' White, etc. Yes 3 Widowed Divorced f Yes, Give Year 1 Yes 2 X No specify: item 27 is marked other than "natural", traumatic event, the Medi al Examiner \$ Specify: black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) permit. Pages I and 2 should be filed within 72 I Department of Health and Menial Hygiene. Important: If item 27 is marked other than "t injury or other traumatic event, th. Medial E College (1-4 or 5+) Student 10 Student 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Alan Zackery Williams, Sr. Paula Thomas Chavis Be ဥ 19a. Infernant'a Name/Relationship Tyse, Print Mother 34 57 in Practices (Savena Number Ballet Rimo Henber, MD or 21 w.), 165 te, Zip Code) Ocean Avenue, Apt 6D, Brooklyn NY 1122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 X Removal from State Staten Island /2010 Frederick Douglass Men. Park, NY 4 Donation 5 Other Specify: 23 Name and Address of Facility Charles I. Stevens Funeral Home, Inc 1501 East Fort Avenue, Baltimore MD 21230 Signature of Funera Service Licensee V1C or P. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical a. Gunshot Wound of the Head Death Immediate Cause (Final disease **xaminer** or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examine (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and transit ian/Medical UNPENDED the attending physician ted for use as the burial AMENDED Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Function After this certificate has been signed by the attending physici completely filled in by the function, page 2 should be deathed for use as the burn. JE FEMALE 23c. If yes, outcome of pregnancy 23d. Date of deliver 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Month past 12 months? Day Year Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 ✔ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy performed? prior to completion of cause of death? ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical Be 26.Place of Death (Check only one) examiner? Hospital: Other Nursing Home 5 Residence 6 Other 1 🗸 Yes Inpatient 2 ER/Outpatient 3 V DOA 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification Oct 26, 2010 1 Natural Subject was shot 0220 hrs Pending 1 Yes 2 V No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide 28f. Location (Street and Number or Rural Route Number, City Could not be or Town, State) 4018 Barrington Road, Baltimore, Md. determined (Specify) Local Street 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal one) 2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 26, 2010 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day Year) 32 Registrar's Signature State 2010

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Sheila Wills 0120 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death arbor Hospital Balti mor If Under 24 Hrs Hours Min. Security Number . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 DM 2 😾 42 Months Days Month, Day, Year) 68 **Director** MD 18-88-129 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of ther than "natural", or items 23a or 28a-f show any injury or other traunatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔽 No MD Anne Arundel Glen Burnie 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 207 Continential Drive 21061 U SA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 ☐ Married ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Greeter Walmart llth grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Thomas Wills, Sr <u>Eleanor Butler</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darren Wills- Son 6240 Chinquapin Parkway Balto, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important; If it any injury or o 1 Marial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-3-2010 Carmel Cem Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Hrrhythmia Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of): To the Hospital or Attending Physician; The law requires that the death certificate be executed signed by the attending physician and dedetached for use on the ball to the beautiful for the ball to that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 1 Yes 2 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Homknown within 24 hours after dec th.

To the Funeral Director. After this certificate has been si completed filled in by the funeral director, page 2 should to 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 LER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a Certifier 1 Fertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) October 22,2010 00062689 30. Name and address of person who completed dause of death (Item 23a) (Type, Print)

State Registrar 32. Registrar's Signature

3001 S. Hanover St. Baltimore, MD, 21225

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 34341

		1- For State Registrar		(	Certific	ate of I	Death			R	eg. No.	1 0	0 .	807
Physici ledical Exam		Decedent's Name (First, Midd	Mary		Will	iams			(	Date of Dea Month October 2	ith Day Year		3. Time of E 1836 h	
		4a. Facility Name (if not institution Johns Hopkins Hospi	-	number)			. City, Town, or L Baltimore	ocation of	Death		4c. County o	f Death		
Funeral Director		5. Social Security Number 218-78-7729	6. Sex	7. Age (In y	rs. last birt $48$	thday) Yrs.	Months Days	If Under Hours	Min.		-1962	9. Birth Foreign Cour	i i	e or MD
MD 21215-0036 42 should be filed within 72 hours after death with the Maryland that and Menial Hygieur Han "natural", or items 23a or 28a-f show any nametic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director		na  ver Stre  12. Was De Armed 1 Yes Vorced of Yes, Give Y. College  College  Nilliams	10c. 6 P Det Decedent Ever i Forces? 2 N Decedent Ever i Forces? 2 N Decedent Ever i N Decedent Ever i	n U.S.	13. Was If Yes 1 Yes 1 Yes during mos	2121 Decedent of Hisp, specify Cuban, see 2 No Usual Occupation to f working life.	specify:  on (Give kind DO NOT use 1.11)	nd of work use retired  Name (Fi	fy Yes or No can, etc.)	White Specify:  16b. Kind of Bus  Maiden Surname)	at Countr - America , etc. B1	an Indian, E ack dustry u	2 No
Baltimore, MD 2 permit. Pages I and 2 shou Department of Health and I Important: If item 27 is ninjury or other traumatic		Cris Willia  20a. Method of Disposition  1XXBurial 2 Cremation  4 Donation 5 Other S  21. Signature of Funeral Service	AMS-SON  Removal	from State K	50b. Place of	203 of Disposition ory or othe Memo	Walthe on (Name of cem place) rial P	r Avetery, k	enue 11-3 Mar	Ra ate 3-10	lto, MI 20c.Location - Randa ast F/E Balto,	21 City or To	214 own, State	, MD
Physician /Medical Examiner		23a. Part I. Egier the disease, or failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line. a. Stab Wou		st	ot enter the	mode of dying, s	such as car	rdiac or re	spiratory arr	est, shock, or hea	rt	Between (	ate Interval Onset and eath
P.O. Box 68760, s that the death certificate be executed good by the attending physician and ediached for use as the burial - transit	Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  UNPENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 V University University 12 Months?	Due to (or as d. AMENDED  23c. If yes 1 Live 4 Preg	, outcome of p	regnancy	Fetal	death 3	Ectopic p	pregnancy	,	23d. Date of o	delivery Da	ıy	Year
Records, The law require icate has been singe 2 should b	Completed by Ph	Part II. Other significant condit		to death but n	ot resulting	g in the und			_	1 Yes  24a. Was autop perfor 1 Yes	rmed? de	Probat	bly 4 lpsy findingsympletion of	Unknown s available
tal certif	Be	25. Was case referred to medica examiner?					26.Place o	,	Check only	one)				
kysic l dire	2	1 ✓ Yes 2 No	Hospital: 1	Inpatient 2					Nursing H	ome 5	Residence 6	Other:		
ling P	ation:	27. Manner of Death  1 Natural 5 Pend 2 Accident Inve	28a. Date FOUNI Stigation Oct 25	e of Injury th, Day,Year) D: , 2010	28b. 1 FOU 1802			at Work? es 2 ✔ N	leu.	d. Describe I bject stat	how injury occurre obed	d		
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	4  Homicide dete	d not be	ce of Injury - A  Residen		rm, street,	factory, office bu	ilding, etc.			Street and Number State) Oliver Street, B			mber, City
Fo the Hos within 24 h Fo the Fui completely	edical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the be miner:On the basis and manner	of examination			, in my opinion,	death occu						
	Σ	29b. Signature and title of certifie	V A				29c. License O.C.M				29d. Date signer October 26,		n, Day, Year	)
		30. Name and address of person Ling Li, MD Assista	who completed cau nt Medical Exa	,	,	Street,	Baltimore, M	1D 2120	1					
	ate	31. Date filed (Month, Day, Year)	32. R	Registrar's Sigr		,								
Regist		NOV 0 3 2010	Special	f. 4	arke	ICINIAL					OCME			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ NOVEMBER Day EVELYN MAE WUNDERER 2010 3:30 A.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 14009 BLENHEIM ROAD, N PHOENIX BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🗆 M 2 🗶 F Months Days Hours Min Director 219-28-2902 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director ortant: If item 27 is marked other than "natural", or items 23a or 28a-f s injury or other traumatic event, the Medical Examiner must be notified BALTIMORE PHOENIX 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14009 BLENHEIM ROAD, N 21131 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates WHITE 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12TH GRADE BOOKKEEPER AUTO SUPPLIES Be permit. Page 1 and 2 should be filet.
Department of Health and Mental Hv.
Important: If item 27 is merany injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 BERTHA STICKLER EARL THORPE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EDWARD P. WUNDERER, SR./HUSBAND 14009 BLENHEIM ROAD, N PHOENIX, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State HIGHVIEW MEM. GAR. 11/4/2010 FALLSTON, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee MOO2 17 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Month Day Year 1 Yes 2 9 Unknown 9 Unknown requires that the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Physician: The law certificate has autopsy performe page Yes 2 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Hospital 1 Yes Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide injury 5 Pending work?
1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Continuing Number Pranties of T. The basis of my income against a factoring of the time date and place, and one to the cause(s) and manner stated Continuing Number Pranties of T. The basis of my income against a factoring of the time date and place, and one to the cause(s) and manner stated Continuing Number Pranties of the cause(s) and manner stated Continuing Number Pranties of the cause(s) and manner stated Continuing Number Pranties of the cause(s) and manner stated Continuing Number Pranties of the cause(s) and manner stated Continuing Number Pranties of the cause(s) and manner stated Continuing Number Pranties of the cause (s) and manner stated Continuing Number Pranties of the cause (s) and manner stated Continuing Number Pranties of the cause (s) and manner stated Continuing Number Pranties of the cause (s) and manner stated Continuing Number Pranties of the cause (s) and manner stated Continuing Number Pranties of the cause (s) and manner stated Continuing Number Pranties of the cause (s) and manner stated Continuing Number Pranties of the cause (s) and manner stated Continuing Number Pranties of the cause (s) and manner stated Continuing Number Pranties of the cause (s) and manner stated Continuing Number Pranties of the cause (s) and manner stated Continuing Number Pranties (s) and manner stated Continuing Number Pranties (s) and manner stated Continuing Number Pranties (s) and manner stated Continuing Number Pranties (s) and manner stated Continuing Number Pranties (s) and manner stated Continuing Number Pranties (s) and manner stated Continuing Number Pranties (s) and manner stated Continuing Number Pranties (s) and manner stated Continuing Number Pranties (s) and manner stated Continuing Number Pranties (s) and manner stated (s) and manner stated (s) and manner stated (s) and manner stated (s) and manner stated (s) and manner state (Check 29b. Signature and title 29c. License number e of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Wilkins 2010 Edward <u>October</u> 7:08 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore If Under 1 Year Social Security Number 7. Age (In vrs. last birthday, If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Days Hours (Month, Day Year) 01/01/1949 North Carolina Director 227-68-1285 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 607 Pennsylvania Avenue, Apt. 21201 S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give "natural", or þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify. Specify Completed 3 Widowed 4 Divorced Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) ath and Mental Hygiene.

27 is marked other than r traumatic event, the M Elementary/Seconday (0-12) College (1-4 or 5+) 12 Warehouse Clerk Produce Distribution Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Willie Hawkins Dollie Marie Wilkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alvin K. Wilkins / Brother item 2 <u>6406 Zinnia Court, Glenn Dale, MD 20769</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1
Department of Important; If it any injury or o once. ō ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatany Gifts Registry 11/03/2010 4 X Donation 5 D Other (Specify) Hanover, Maryland . Signature of Fuveral Service Licens Anatomy Gifts Registry 22. Name and Address of Facility 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the dis complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Examiner

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director After this certificate has been signed by the other death. P.O. Box 68760

Physician/Medical Examiner Certificate: To Be Completed by

Medical

Natural

4 Homicide

29a. Certifier

(Check

only one) 29b. Signature a

Accident

Suicide

5 Pending

title of dertifier

Investigation

Could not be

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KUMA R

	Due to (or as a consequence of).			
fany, leading to immediate	b. — Due to (or as a consequence of):			
that initiated events resulting in death) Last	c			
	d			
FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23d. Date of delivery Month Day Y	⁄ear		
art II. Other significant conditions	s contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco u	use contribute to the cause of de	eath?
		1 🔀 Yes 2	☐ No 3 ☐ Probably 4 ☐ I	Jnknown
		24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ N	24b. Were autopsy findings a prior to completion of codeath? 1 \sum Yes 2 \sum No	vailable ause of
5. Was case referred to medical	26. Place of Death (Check on	ly one)		
b. Due to (or as a consequence of):    Due to (or as a consequence of):	5 ☐ Residence 6	S Other (Specify) HOSA	ia	
7. Manner of Death	28a. Date of injury 28b. Time of 28c. Injury at 28d	y occurred		

Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

N Charles ST

1 ☐ Yes 2 ☐ No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D71040

28f. Location (Street and Number or Rural Route Number,

01

Tousleur

29d. Date signed (Month, Day, Year)

2010

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Registrar

To the within 2

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be

Division of Vital Records,

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

(Month, Day, Year)

6701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ BOHDAN WOJTOWYCZ Month 2010 A M November 8:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel 237 MARGATE DRIVE Glen Burnie 8. Date of Birth 9. Birthplace (State or Foreign Country)
Ukraine Social Security Number 7. Age (In vrs. last hirthday If Under 1 Year If Under 24 Hrs. Funeral Jan 1. 1926 1 🙀 M 2 🗆 F Days 213-30-7579 Director 84 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Maryland Anne Arundel Glen Burnie 28a-f 1 Yes 2 X No 0 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a Completed by Funeral 237 Margate Drive 21060 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S Race - American Indian. Armed Forces Black, White, etc. ò 1 Never Married 2 X Married 2 🕱 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White If Yes, Give "natural" 3 Divorced 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Carpentry Cabinet Maker ath and Mental Hygie

27 is marked other

r traumatic event, the Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Tekla Zalopany Semen Wojtowycz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 short of Health a item 27 is Nadia Wojtowycz (Wife) 237 Margate Drive, Glen Burnie, Maryland 21060 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Department of Important; If any injury or once, 4 Donation 5 Other (Specify) St. Michael's Ukrainian Cem 11/5/10 Dundalk, Maryland McCully-Polyniak Funeral Home, P.A. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Kevin E Ecker 237E. Patapsco Ave., Baltimore, Maryland 21225-1856 Approximate Interval Between Onset and Death 23a, Part 1. Enter the disease, or complications to at caused the death, Do not enter the Immediate Cause (Final disease or condition .Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Completed by Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant P.0. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? performed this certificate 2 No 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Certificate: To Be examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 280. Describe how injury occurred I or Attending P safter death. I Director: After 5 Pending work? 1 ☐ Yes 2 ☐ No Natural Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State ie Hospital o 24 hours ar e Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 29 <sup>ay</sup> 2010 Constance Ann White 7:05 ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore Social Security Number 8. Date of Birth (Month, Day, August 29 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🕱 F Country) Mary Land 219-30-5827 75 Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location Director 10d. Inside City Limits Maryland Baltimore Essex 1 Yes 2 K No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1003 Middlesex Road 21221 U.S.A. death 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. "natural", or Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after Yes 2 **X**No 1 ☐ Yes 2 🔀 No Specify: If Yes, Give 3 K Widowed 4 Divorced Specify: White Completed Year or Dates traumatic event, the Medical 15 Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 12 Clerical Eastern Products, Inc. Be Page 1 and 2 should be filed in the properties of Health and Mental Hyyant: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Julia Miller Melvin Unger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wanda Lee Stefan daughter 1003 Middlesex Road, Essex, Maryland 21221 other 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of F Important: If ite Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State injury or Loudon Park Cenetery Nov. 2, 2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McCully Polyniak Funeral Home, P.A. 130 Fast Fort Avenue Baltimore, Maryland 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of). the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Pregnant at time of death 5 Other (specify) Day Year 2 should be detached g | Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? extension 24a. Was an this certificate has page performed?" Yes 2 No 1 🗌 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) 2XNo Hospita Other: 1 🗆 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗷 Other (Specify) 🔫 🔾 Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after death To the Funeral Director. Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. cal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29d. Date signed (Month, Day, Year) 00071287

Registrar
DHMH 17 Rev 7/2009

State

- Suite 4105, Baltimore, MD 21204

Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701 N. Char

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Dav ntecs COC 2010 10:00 PM 20 Medical exand 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death barles Sina 8. Date of Birth Birthplace (State or Foreign Country) JNK **Funeral** If Under 24 Hrs. Min. (Month, Day, 1 M 2 🗆 F Months Days Director Yrs. 214-18-853 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c, City, Town or Location 10d. Inside City Limits Director 1 XYes 2 ☐ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20734 MPK 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) UNK 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. Maryland 21215-0036 1 Yes 2 No Specify. 3 Widowed 4 Divorced Specify: 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry VIVK (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 8 +1 bore Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental Important: If Item 27 is marked o any injury or other traumatic eve ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing-Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tobacco 20677 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) DateJNK 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of uneral Service 22. Name and Address of Facility 18434 PA Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Atherosc 107 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Secus tiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran signed by the attending physician and that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 124 hours after death.

e Funeral Director: After this certificate has been signe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: မှ 1 🗌 Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 🔲 Yes 28d. Describe how injury occurred 1 Natural 5 Pending Investigation 2 🔲 No ☐ Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rd Suit 101 Camp Springs Allentown Fatima Hussein 025 31. Date filed (Month, Day, Year) 82. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

NOV 03 2010

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

indrea Yutzy		S1 1- For State Registrar	tate of Maryla		artment of ertificate of		d Mental I		201 Reg. No.	0 34348			
Physicia Medical Examir	n/	Decedent's Name (First, Midd Andrea Lynne Yu						2. Date of De Month October	ath Day Year 18, 2010	3. Time of Death 1619 hrs			
		4a. Facility Name (if not institution 4922 Columbia Road	on, give street and nu	umber)		4b. City, Town, or I Columbia	Location of Dea		4c. County of Howard	Death			
Funeral Director		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)  35 Yrs	If Under 1 Year Months Days		in.	e of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign				
y		216-04-4759 Usual Residence of Decedent 10a, State 10b, County		Inc. City	, Town or Locat			02/22	2/1975	Country) Maryland  10d. Inside City Limits			
Maryland 28a-f show any 1 at once,	'n	10a. State 10b. County  Maryland Howai		Toc. City	Colum					1 Yes 2 X No			
e Maryla or 28a-f	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Count 4922 Columbia Road Unit #2 21044 U.S.A.								-			
eath with the Maryland items 23s or 28s-f sho ust be notified at once	Funeral D	11. Marital Status  1 XX Never Married 2 M	12. Was Dec	cedent Ever in U		21044 s Decedent of Hisp es, specify Cuban,			U.S.	American Indian, Black,			
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hin 72 houre. e. than "nathedical Exa	Completed	Elementary/Secondary (0-12)		1-4 or 5+)	during m	ost of working life. ered Nurse	DO NOT use re		Hospic				
	Be Con	17. Father's Name (First, Middle Robert L. Yutzy							Maiden Surname)				
MD 21 nd 2 should alth and Men m 27 is man aumatic ev	의	19a. Informant's Name/Relations Chery1 Varnum-Gle		r)		,			mber, City or Town, ty, Maryland				
2	ŀ	20a. Method of Disposition  1 X Burial 2 Cremation		20b.		ition (Name of cem		Date	20c. Location - Ci				
Baltimore, permit. Pages 1 ar Department of Hec Important: If itel injury or other tr	-	4 Donation 5 Other States 21. Signature of Funeral Service	Licensee	Mea	dowridge   22. N	Memorial Pa ame and Address	ark 10- of Facility Wi	23-2010 tzke Fune	Elkridge, ral Homes, 1	Maryland nc.			
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/Medical Examiner		failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line. _Multipl	e drug	intoxic	ation (Fl	lecaini	de, Paro		Between Onset and Death			
, A		Sequentially list conditions.											
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	consequence o									
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ath ath	Siciar	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)											
P.O. Bost that the degree of detached for	<u>ا</u> ھ	Part II. Other significant condit			esulting in the u	nderlying cause gi	ven in Part I.			e to the cause of death?  Probably 4 V Unknown			
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Vital Rec	Be Co	25. Was case referred to medica	1			26.Place	of Death (Chec	1 Yes	2 No 1	Yes 2 No			
of Vital ng Physician: Ther this certi	의	examiner?  1  Yes 2 No  27. Manner of Death	Hospital: 1 28a. Date	npatient 2	ER/Outpatient 28b. Time of Ir	O DOX	Other   Nurs	ing Home 5	Residence 6 🗸				
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Division To the Hospital or Attent within 24 hours after death To the Funeral Director completely filled in by the	Certification:	4 Homicide deter	mined (Specify)	res	idence	t, factory, office bu		-	·	r Rural Route Number, City Lumbia Road			
To the Hospital within 24 hours To the Funeral completely filled	ωl		nysician: To the bes miner:On the basis of and manner s	of examination a	ge, death occuri ind/or investigati	ed at the time, date on, in my opinion,	e and place, an death occurred	d due to the cau at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)			
	ž	29b. Signature and title of certifie		1/m		29c. License O.C.M			29d. Date signed October 19, 2	(Month, Day, Year)			
		30. Name and address of person Melissa Brassell, MD	who completed caus Assistant Me	·		enn Street, Ba	altimore, ME	21201	· · · · · · · · · · · · · · · · · · ·				
Sta Registr		31. Date filed (Month, Day, Year)		gistrar's Signatu	barks	,		-		<del> </del>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Conth 255 PM Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Seasons Hospice Baltimore Randallstown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
New York 8. Date of Birth **Funeral** (Month, Day Year) 1 XM 2 - F Months Days Hours Min Director 93 26-10-9268 Usual Residence of Decedent 3a or 28a-f show be notified at and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Hen 27 is marked other than "natural", or items 23a or 28a-1 show 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Md. Baltimore Timonium 1 🗆 Yes 2 🛣 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a Examiner must be Funeral 620 Straffan Drive #201 21093 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐xNo Specify: Specify: White 3 ₩ Widowed 4 □ Divorced Year or Dates ed other than "nature event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Rep. Food Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ William Yonych Marv Solecka 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 18803 Fox Chase Ct. Parkton, Mrs. Gerry Laue/ Daughter Md. 21120 other nt of Hea t: If item or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place permit. Page Department of Important: If any injury or Moreland Mem. 11-3-10 Park Baltimore, Md 21. Signature of Inera Service Licens 22. Name and Address of Facility Ruck Towson Funeral Home, York Rd. Towson, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or iinjury Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and the for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Day Year 4 ☐ Pregnant 9 ☐ Unknown s been signed by the same should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🎾 Unknown Director: After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 No 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Other: 1 🗌 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident 1 Tyes 2 🗆 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one) 3 🗌 29b. Signature and title of certifier

State Registrar

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DHMH 17 Rev 7/2009

death (Item 23a) (Type, Print)

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32. Registra

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10g Per FH G909 11/03/10 JH State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Dristan Le 11:09 Medical 50:1 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 16. Sex Baltimore Northwest . Age (In yrs. last birthday) If Under Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) 1 □ M 2 🕅 F Months Days Hours Min 047297 1946 337-40-6217 64 Yrs Director RI Usual Residence of Decedent show 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits ral", or items 23a or 28a-f s Examiner must be notified 1 ☐ Yes 2 🛣 No BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 11 POMONA SOUTH, 21208 YEC 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes Give "natural", 3 Widowed 4 Divorced Specify. Year or Dates WHITE permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I sone. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) FUND RAISING DEVELOPMENT EDUCATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ **EDMUND** M COLLINS KATHARINE MORRIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STEVEN YASINOW/HUSBAND 11 POMONA SOUTH, #9, PIKESVILLE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗐 Removal from State 4 Donation 5 Other (Specify) MONTEFIORE CEMETERY | 10/31/2010 ABINGTON TOWNSHIP, PA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility  $\,$  SOL LEVINSON & BROS., INC. Man Le 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition arriva reaches de Medical resulting in death) Due to as a consequence of Examiner Mylloren Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events southing in death). Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi the attending physician and thed for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
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To the Funeral C

completed filled Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D005663

DHMH 17 Rev 7/2009

State Registrar 30. Name and addless of per

31. Date filed (Month, Day Year)

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Vear EWIS ZOLLARS PM 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Elkridge Howard 6513 <u>Reile</u> Drive 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 56 (Month Payo Yaar) Maryland 1954 212-64-4758 Yrs Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 Yes 2 No Howard Elkridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21075 6513 Reile Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married þ ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: White 3 Divorced 4 Divorced Completed Year or Dates. 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Carpenter Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Marie Magdaline Hoffman William Frank Zollars 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Zollars /Daughter Drive Elkridge, MD 21075 Kimberly 6517 Reile 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Datoct 30 1 Burial 2 Cremation 3 Removal from State Beltsville, Maryland 2010 Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Narkanamaticon Fand Funeral Alternatives 21. Signature of Funeral Service Licensee 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ LIVEY disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Yes 2 X No 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Director: After X Natural 5 Pending 1 Yes 2 No Investigation Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a

To the Funeral C

completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. The detail of the best of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anna Lew 15 6701

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

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Registrar DHMH 17 Rev 7/2009

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31. Date filed (Month, Day, Year) **0CT 18 2010** 

Box 68760

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month Douglas Harold Bittinger Medical 4a. Facility Name (if not institution, give street and number) Examiner City, Town, or Location of Death 4c. County of Death If Under 24 Hrs. Hours Min. Social Security Number If Under 1 Year Funeral 8. Date of Birth 9. Birthplace (State or Foreign Months 1 **X** M 2 □ F Days (Month, Day, Year) 01/24/1942 Country) Director 213-40-3500 68 Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Garrett Mt. Lake Park 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 310 Baltimore Ave 21550 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married à ☐ Yes 2 X No Yes, Give Maryland 21215-0036 1 Tes 2 No Specify: "natural" Completed 3 Widowed 4 Divorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Machinist <u>Automotive</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Delbert Bittinger Ina G. Mover 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 310 Baltimore Ave, Mt. Lake Park, MD 21550 Sue E. Bittinger-wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 10/24/2010 Gardens Oakland, MD 4 Donation 5 Other (Specify) Garrett Co. Memorial Sign sture of Funeral Service Licensee 22. Name and Address of Facilit David A. Burdock Funeral Home P.A. CUMM 2nd St, Oakland, MD 21550 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Esque tially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami that the death certificate be executed and -tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown P.O. I signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, The law requires cate has been si Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No perform certificate Division of Vital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 124 hours after death.

le Funeral Director: Af
pleted filled in by the fu 2 🗌 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Tipleted i Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2

To the F

complet Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of compe 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

OCT 25 2010

DHMH 17 Rev 7/2009

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item £3a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State		State	of Mary	land / Dep	oartmei ertificat			and M			2111	0	34355
	Physicia	un/	1. Decedent's Name (First, M.	. ,		<u></u>		rinoat	.0 01 L	- Catin		2. Date of De				3. Time of Death
an an angle	Medi	ical							Month oc Lobe  4b. City, Town, or Location of Death							5:50 a M
.,,,,,,,	Examir	ier	Suburban Hospit		ireei arid ridi	nber)		1 '	, iown, or hesda	Location	of Death			ic. County of D Mont		ery
	Funeral Director		5. Social Security Number 231–42–2899	6. Sex	M 2 <b>X</b> F	7. Age (In <b>74</b>	yrs. last birthday Yrs.	If Unde Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Bir July 14,		36	Birthpla Couptn	ace (State or Foreign rginia
	/land f show ed at	tor	Usual Residence of Decedent  10a. State 10b. Cou	nty		10	c. City, Town or L	ocation							10	d. Inside City Limits
	r 28a- notifie	Director	MD 10e. Street and Number	Montg	omery		Kensingto		p Code				10 /	Oiling of Miles	Carret	1 🗌 Yes 2 🙀 No
	with the s 23a c ust be	Funeral	3230 Geiger Av		895				rug. (	Oitizen of What USA	Countr	y r				
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: I item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status  1 ☐ Never Married 2 ☑  3 ☐ Widowed 4 ☐ Divo	Married	12. Was Dec Armed For 1 Yes If Yes, Gi Year or D	orces? 2 XNo ve	in U.S. 13	. Was Dece If Yes, spe 1  Yes	cify Cuba	n, Mexican	, Puerto	cify Yes or No- Rican, etc.)		14. Race - Al Black, W Specify: Wh	hite, et	
1215-	thin 72 hou ene. than "nat he Medica	Completed	15. Dec (Specify only h Elementary/Seconday (0-1				(Giv.	edent's Usu e kind of wo DO NOT us sing Gu	ork done a e retired)		t of worki	ng		Kind of Busine		·
and 2	ntal Hygie ed other event, the	To Be (	17. Father's Name (First, Midd Willie Edwards	le, Last)			Cross	ang Gu	ard		er's Name	e (First, Middle,	1		erm	Lenc
Maryland 21215-0036	d 2 should thath and Me alth and Me 1 27 is marker traumatic		19a. Informant's Name/Relati							nd Numbe	er or Rura		per, City or Town, State, Zip Code) 20895			de)
Baltimore,	Page 1 and nent of Her ant: If item ary or othe		20a. Method of Disposition 1 😾 Burial 2 □ Cremate 4 □ Donation 5 □ Oth		Removal fron	n State	20b. Place of Disp cemetery, cri Gate of He	ematory or o	other plac		Oct.	Date 18 0		Location - City		
Balti	permit. Departr Imports any inji		21. Signature of Funeral Servi	ce License	ole-			2. Name a Franci 500 Un	nd Addres S J. ( ivers:	solEacilit Ollin ity Bl	s Fund	eral Home	e Ind	c. ring,MD 2	20903	L
	Pnysician,	- 2	23a. Part 1. Enter the disease shock, or heart failure. L Immediate Cause (Final disease or condition	, or compli ist only one			death. Do not en		de of dying	g, such as	cardiac o	r respiratory ar	rest,		1 1	Approximate nterval Between Onset and Death
	Medical Examiner		resulting in death)	r°			nsequence of): P <b>leural</b> Ef	fusion								-
	D it Q	Examiner	Sequentially list conditions, if any meding to immediate cause. Enter Underlying Cause (Disease or iinjury	1	Due to	or as a co	nse wence of									_
	icate be executed physician and is the burial-transit	al Exa	that initiated events resulting in death) Last		Due to	(or as a co	nsequence of): unq Cance:	<del></del>							$\dagger$	
3760	ficate b g physi as the k	<b>dedical</b>			i											
P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼ No 9 ☐ Unknown	23		Birth 2 D	Fetal death 3	☐ Ectopic ☐ Other (s		У			1	23d. Date of Month		/ day Year
s, P.O.	requires that the de been signed by the should be detached	d by Ph	Part II. Other significant con	ditions con	tributing to o	death but n	ot resulting in the	underlying	cause giv	en in Part I	l.					cause of death?
Division of Vital Records,	e law requ s has been ge 2 shoul	mplete					-					24a. Was autop		prior t death	to com	y findings available pletion of cause of
a E	ian: Th stificate stor, pa		25. Was case referred to medi examiner?						26. Pla	ice of Deat	th (Check	1 \(\superstack Yes\) only one)	2 <b>X</b>	No 1 □ `	Yes 2	∐ No
Ę	Physic this ce al dire	욘	1 Yes 2 No	l He	ospital: 1 🛣 28a. Date		2 ER/Outpati			4 ∐ Nu				6 Other (Sp	ecify)	
o uc	ath. r: After re funel	icate	1 🛣 Natural 5 □ Pe 2 □ Accident _ Inv	estigation	(Mor	nth, Day, Ye	ar) injury	M	28c. Injury work' 1 🗆	Yes 2	- 1	28d. Describe h	iow inju	ary occurred		
Division	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2	Certificate:		uld not be ermined		of Injury - ing, etc. (S <sub>f</sub>	At home, farm, so	reet, factor	y, office		1	28f. Location (S City or Tow		nd Number or i	Rural R	oute Number,
	ne Hospit n 24 hour ne Funera pleted fill	Medical	(Check 2 Medic	al Examine	er: On the ba	sis of exami	knowledge, death nation and/or inve of my knowledge	stigation, in	my opinio	n, death oc	curred at	the time, date a	nd plac	ce, and due to th	ne caus	e(s) and manner stated
	10		29b. Signature and title of cert	ifin		Š		290	c. License	number 66 8	60	1	29d. D	ate signed (Mo	nth, De	y, Year) 7
			30. Name and address of pers				(Item 23a) (Type, orgetown 1		ethes	đa, MD	2081	4				
	Sta Registra		31. Date filed (Month, Day, Yea	2010	Se s	Registrar's S	Signature A	del.								

DHMH 17 Rev 7/2009

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	,		State Registrar				tificate of L			erie 2	01	0 3435	
	Physicia Medi		Decedent's Name (First, Middle,	IET B	102				2. Date of Death  Month  Day  Year  3. Time of Death  Year  13 7010  10 55				
_	Examir	ner	4à. Facility Name (if not institution, Howard Coun				4b. City, Town, or Colu	Location of Death Imbia		4c. Count	y of Deat HOWa	ird	
	Funeral Director		114-05-1142	6. Sex 7. Ag	e (In yrs. last birti 91	<i>hday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 9 (Month, Day)	949	9. Bir N •	thplace (State or Foreign	
	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examiner must be notified at	ector	Usual Residence of Decedent	rd	10c. City, Town		10d. Inside City Limits						
		eral Dir	108 Street and Number 8537 Tamar D:	rive			10f. Zip Code 21	1045	10	)g. Citizen of	What Co	buntry?	
9036		Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marri 3 🏝 Widowed 4 ☐ Divorced	12. Was Decedent B Armed Forces? 1  Yes 2 If Yes, Give Year or Dates.	ss? If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  Black, W  1 □ Yes 2 ☒ No Specify:						ck, Whit	rican Indian, e, etc. nite	
21215-0036			15. Deceden (Specify only highes Elementary/Seconday (0-12)			(Give F	lent's Usual Occup kind of work done of NOT use retired) Bookkeep	luring most of work	ing 1	16b. Kind of Business Industry  Real Estate			
Maryland		To Be	17. Father's Name (First, Middle, La Abraham Ros	e (First, Middle, Ma Nadler									
			19a. Informant's Name/Relationsh Bruce Broz/S					nnd Number or Rura Drive (	al Route Number, Columbia	ity or Town,  A, Ma:	yorTown, State, Zip Code) , Maryland 21045		
Baltimore,	Page nent c		20a. Method of Disposition  1 XBurlal 2 Cremation  4 Donation 5 Other (St	pecify)	20b. Place of cemeter Eteri	y, crem nal	sition (Name of natory or other place Light Ga	Mem 10/	18/2010	0c. Location Boy	nto	n Beach,FL	
Ba	permit. Departn Importa any inju		21. Signatur of Funeral Service Li			₽Ħ 92	11 Colu	RTNALDI mbia Bl	FUNERA vd.Silv	L SER er Sp	rin	E,P.A. g,Md20910	
أحسيه	Physician/ Medical Examiner		23a. Part 1. Enfer the disease, or a shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	ify one cause on each line	the death. Do not			G, such as cardiac o				Approximate Interval Between Onset and Death	
0		al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a Due to (or as a Due to (or as a	ras a consequence of):  >EBILITY ras a consequence of):  =TASTATIC BREAST CA								
Box 68760	Attending Physician: The law requires that the death certificate be executed ar death.  **redeath.** estor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant In the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome	Birth 2 Fetal death 3 Ectopic pregnancy nant at time of death 5 Other (specify) Mont							ivery Day Year	
1s, P.O.	w requires that the dea s been signed by the a should be detached t	by	Part II. Other significant condition	s contributing to death b	ut not resulting in	n the ur	nderlying cause giv	en in Part I.				the cause of death?	
Division of Vital Records,	The law req	Completed			-				24a. Was an autopsy performe	psy prior to completion of cause of death?			
Vita	ysician: The is certificate director, pag	To Be	25. Was case referred to medical examiner? 1  Yes 2  No	Hospital:	ent 2 🗆 ER/Out	toatien	0	er:	only one) me 5 🗆 Residen	ce 6 Oth	ner /Snec	ifu)	
on of	inding Ph ath. r: After thi ne funeral	Certificate: 7	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ AccidentInvestigate	28a. Date of injur (Month, Day	y 28b. Ti		28c. Injury work	at	28d. Describe how				
Divisi	tal or Atters after de al Directo ed in by the	I Certif	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin		ry - At home, far . (Specify)	m, stre	et, factory, office		28f. Location (Stre City or Town,		er or Rui	al Route Number,	
	To the Hospital or Attending Physician: within 24 hours after death. We the Funeral Director: After this certific completed filled in by the funeral director,	Medical	(Check 2   Medical Exonly one) 3   Certifying I	Physician: To the best of aminer: On the basis of ex Nurse Practioner: To the b	camination and/or	investi	gation, in my opinio	n, death occurred at	the time, date and	place, and du	e to the	cause(s) and manner stated.	
	To the within 2 to the complex complex complex to the complex to t		29b. Signature and title of certifier	M.D			29c. License	6964		d. Date signe		1, Day, Year)	
			30. Name and address of person w	ho completed cause of de			rint)		BEAM			UMBIA MOZI	
	Stat Registra	re	31. Date filed (Month, Day, Year)	3. Registra	r's Signature	bar	Ked.			*-			

Division of Vital Records, P.O. Box 68760

Physician/

Medical

Director

Funeral

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Completed

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**Examiner** 

**Funeral** 

**Director** 

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27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at

permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than 's any injury or other traumatic event, the Meany ence.

Physician/

Examiner

Medical

within 72 hours after death

Baltimore, Maryland 21215-0036

Examine Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and dedetached for use as the burial-transit resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant þ Completed been has 24 hours after death.

Funeral Director: After this certificate funeral director, 25. Was case referred to medical Be P 27. Manne of Death Certificate: 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one 29b. Signature and title of certifier 29c. License number

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WJL STIVA

State Registrar ert

31. Date filed (Month, Day, Year)

alco

29d. Date signed (Month, Day, Year)

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2010 Year **Physician** Month October 15, Mary Helen Brown 4:30 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Wilson Health Care Center Montgomery Gaithersburg 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** . 1938 1 M 2 XF Director 72 063-32-0787 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 Is marked other than "natural", or items 23a or 28a-f sho traumatic event, I'be, Medical Examiner must be notified at Director 1 X Yes 2 No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 203 Tulip Drive 20877 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No \$ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "nat any hijury or other traumatic event, I'm Medee once. 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Teacher Pre School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Elliott Katherine Moriarty 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) #4 Hutton Street, Gaithersburg, MD 20877 Padraic Brown (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Date 20c. Location - City or Town, State 15, October 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 Crematory Alexandria, Virginia 21. Signature of Funeral Service Licensee DeVol Funeral Home, 22. Name and Address of Facility M00689 10 East Deer Park Drive, Gaithersburg, MD 20877 23a. art 1 bute the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hoc or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Idio Physician disease or condition resulting in death) /Medical Due to (o as a consequence Examiner Sequentially list conditions, if any leading to impression cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 2 🗷 No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

P.O. Box 68760. Division of Vital Records,

Hospital or Attending Physiclan: The law requires that the death certificate be executed for use as the burial traattending physician detached à signed to After this certificate has been si funeral director, page 2 should I You the Hospina.

# within 24 hours after death.

To the Funeral Director: After a consistely filled in by the fur

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72 hours after

Baltimore, Maryland 21215-0036

State Registrar

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20/ RUSSELL AVENUE.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Steven Victor BROIDER October 0 2010 23 Р Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number 8. Date of Birth (Month, Day, Apr. 12 If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours Min. 1 💢 M 2 🗆 F 949 Washington. Director Yrs. 231-68-6969 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturo" any injury or other traumatic energy. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Rockville 1 ☐ Yes 2 No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20854 5 Kettle Pond Court United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 1969
If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1969 1 ☐ Yes 2 ☒ No Specify white Completed 3 Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Government Computers Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Shirley Kaitlin Leonard Broider 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Kettle Pond Court, Rockville, MD Adrienne J. Broider, Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 10/17/10 1 V Burial 2 Cremation 3 Removal from State 4 Donation 5 Qther (Specify) King David Memorial Falls Church, VA Garden or Funeral Sarv ce Licensee 22. Name and Address of Facility
Torchinsky Hebrew Funeral Home 01008 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Washington, DC Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Year Pregnant at time of death 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate 1 Yes 2 No Yes 2 No Division of Vital To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No 은 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 28b. Time of 27, Manner of Death Certificate: 28c. Injury\_at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide City or Town, State) within 24 hours a

To the Funeral I Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Gertifying Nurse Frantionen To the best of my knowledge, de 29b. Signature and the of

Registrar DHMH 17 Rev 7/2009

State

(V)

0

1400 Forest Glen Rd #200 Silver Spring

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

. Registrar's Signature

PETER J. SABIA, MD

31. Date filed (Month, Day, Year)

29d. Date signed (Month. Day, Year) October 14

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 14. Day 2010 6:55 a VIAN D. BLANKENSHIP Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Springbrook Adventist Nursing & Rehab. Silver Spring Montgomery If Under 1 Year If Under 24 Hrs Months Days Hours Min. Social Security Number 6. Sex . Age (In vrs. last birthdav 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MS 1 🗆 M 2 🛣 F Jan. 2ay, 1926 426-42-4813 84 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at should be filed within 72 hours after death with the Maryland nand Mental Hygiene. I so marked other than "natural", or items 23a or 28a-f shor raumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 X No Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? Funeral 721 Milestone Drive 20904 USA 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: White 3X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Montgomery County Crossing Guard Poliče Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ t. Page 1 and 2 should be treent of Health and Menterant: If item 27 is marked jury or other traumatic e Edgar E. Smithon Alice Edmonds 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy Elaine Finnin/Daughter 721 Milestone Drive, Silver Spring, MD 20904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 19, Parklawn Memorial Park 4 Donation 5 Other (Specify) 2010 Rockville, Maryland . Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins 500 University Blvd. Funeral Home Inc. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Chronic Obstructive Pulmonary Disease Medical Due to (or as a consequence of) Examine Conjustive Heart Failure Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) s been signed by the attending physician and should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Artery Disease that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical End-Stage Renal Disease Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year 4 Pregnant : 9 Unknown Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Respiratory Distress due to COPD 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 👿 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) Hospital 1 Yes 2 X No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? \_\_1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred injury 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 2 29d. Date signed (Month, Day, Year) 116833 emoll 30. Name and address of person who completed dayse of death (tem 23a) (Type, Print) Lemolls Johny, CRNF 20850 245 SHADYGROVE RUAD 31. Date filed (Month, Day, Year) State 18 Registrar

State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ELLEN RUTH BROWN 3:25P M October 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Harford Bel Air 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 1 - M 2XXF Days Hours **Director** 235-52-8391 78 2/1932 WV Usual Residence of Decedent er than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Harford Whiteford 1 🗌 Yes 2 😾 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1575 Main Street 21160 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinane. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: § Widowed 4 □ Divorced Specify: White Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Unknown Public Utility Telephone Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Calvin Blake Ressie Cutlip 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6260 Quarter's Road, Woodford, VA Emily G. Brown/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Ridge Cem. 10/27/2010 Delta, PA Slate 21. Signature of Fun ervic / icen ee 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Anoxic Ph sician/ encephalopato disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Condiac Sequentially list conditions, Examine trany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of, that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day 5 Other (specify) Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy
performed?

Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director After at Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) Division of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural work?
1 \( \sum \) Yes 2 \( \sum \) No 5 Pending injury 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D 63420 October 17,2010 hel la 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 upper chesapeake Dr. Bel Air MD 21014 Sid 2. Kharal 31. Date filed (Month, Day 32. R strar's Signature State GASUA Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Physicia Medic Examin

Funeral Dírector

Baltimore, Maryland 21215-0036

Rermit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/ Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

	For State Registrar		State of M	aryiand	•		t of Hea of Dea		ivient		ene 🐃 🔌		
n/	1. Decedent's Name ANAN CHE	,	st)							ate of Death 100/10/2		Year	3. Time of Death
al .			e street and number)			4b City	Town, or Loc	ation of De		U/ ±U/ 2		ity of Death	1537
er			ntist Hosp	ital			ville	mon or be	aur			gomer	
	5. Social Security Nu 212-87-8. Usual Residence of	525 <sup>1</sup>	Eex 7. Age 7. Age 4	e (In yrs. last	birthday) Yrs.	If Under Months		Inder 24 H ours Mi		ate of Birth fonth, Day, 1		g. Birth	nplace (State or Foreign ntry) Wan
- 1	10a. State	10b. County			Town or Loc	ation				-			10d. Inside City Limits 1 X Yes 2 □ No
<u>i</u>	MD 10e, Street and Num	Montgome ber	ery	Rocki	/11ie	10f. Zip	Code			1 10	Og. Citizen o	f What Cou	
eral	21 Yearl:	ing Court	_			208					'aiwan		,
E	11. Marital Status		12. Was Decedent E Armed Forces?	ver in U.S.	13. W	Vas Deced	ent of Hispar	ic Origin? (	(Specify Ye	es or No-	14. R	ace - Ameri	
ed by	1 Never Marri	ied 2 💢 Married 4 🗌 Divorced	1 Yes 2 XI If Yes, Give Year or Dates.	No	1		fy Cuban, M		erto racan,	etc.)	Speci	fy: AS	ian
Completed by Funeral Director	(Spec	15. Decedent's E cify only highest gr anday (0-12)			(Give k		Occupation done during retired)	most of w	vorking	1	6b. Kind of	Business Ir	ndustry
au l			4		None						None		
일	17. Father's Name (F Zhen Huar								Name (First Nan Ge	, Middle, Ma <del>)</del>	a <i>id</i> en S <i>ur</i> na	me)	
	19a. Informant's Na				19b. Mailin	g Address	(Street and f	lumber or l	Rural Rout	e Number, C	City or Town	State, Zip	Code)
	Kuang-Mir		husband	1001 51			ng Cou	rt, R					
	1 🗆 Burial 2		Removal from State	cen	ce of Dispos netery, crem ent	atory or of	e or her place) LON SV	2 10	Date /14/2		loc. Location Hanov	-	
	21. Signature of Fur	neral Service Licens	Ran	vue	Z / /		Address of						
	23a. Part 1. Enter the shock, or hear Immediate Cause (F	t failure. <b>L</b> ist only c	plications that caused on cause on each line		o not ente	r the mode	of dying, su	ch as cardi	iac or respi				Approximate Interval Between
	disease or condition resulting in death)		a. Meta	a consequer	ice of):	₩.	<del>}</del>	ance	_				onsor and board
Jer	Sequentially list cor if any, leading to im	mediate	b. Hepe	tic	Fail	ure						Onset and Death	
xamii	cause. Enter Under Cause (Disease or i that initiated events resulting in death) L	rlying iinjury	c. Due to (or as a	consequer	oce off:								
edical Examiner	Todaking in dealing E		d										
	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outcome	of <u>pr</u> egnanc	у						234 [	Date of deliv	ven
ysicia	in the past 12 n 1  Yes 2 9  Unknown	nonths?	1 ☐ Live Birth 4 ☐ Pregnant a g ☐ Unknown			Ectopic p Other (sp						/onth	Day Year
Completed by Physician/M			contributing to death b		ing in the ur	nderlying c	ause given ir	Part I.	2				the cause of death?
plete	Cae	and a a t	hy trafficien	7					2	4a. Was an	241	. Were auto	opsy findings available
autopsy performed? death?  1 \( \text{ Yes 2 \text{ No. } 1 \( \text{ Yes } \) Yes									death?	ompletion of cause of			
mĭΙ	25. Was case referre examiner?  1  Yes 2		Hospital:			🗆	26. Place of Other:	,					
e: 10	27. Manner of Death		28a. Date of injur		3b. Time of		Bc. Injury at	<u> Nursing</u>		Residen			<u>y)</u>
ficat	1 Natural 2 Accident 3 Suicide	5 Pending Investigation		, Year)	injury	М	work? 1 ☐ Yes	2 🗆 No					
Certi	4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of Inju building, etc		e, farm, stre	et, factory,	office			ocation (Stre ity or Town,		ber or Rura	al Route Number,
Medical Certificate:		Medical Exam	sician: To the best of iner: On the basis of ex se Practioner: To the	xamination a	nd/or investi	gation, in n	ny opinion, de	ath occurre	ed at the tin	ne, date and	place, and o	lue to the ca	ause(s) and manner stated.
	29b. Signature and t			,	J		License num				d. Date sign		
	Paul	Bannen	Mp				0060	335	•	0	cto be	e 11,	2010
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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day 2010 Year October 9, Lula Mae Compher 1258 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 221 Mildale Drive Salisbury Wicomico 8. Date of Birth (Month, Day, Year) June 10,1927 If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1 □ M 2 X F Months 152-18-5817 Director 83 Maryland Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 221 Mildale Drive 21804 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛱 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event. If the later than "natural", or iten any injury or other traumatic event. Black, White, etc. 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: ð Specify White 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Line Worker Food Processing 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Raleigh Marine ၉ Sadie Insley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tammy M. Legates/Granddaughter 221 Mildale Drive, Salisbury, Maryland 21804 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Buria! 2 🛣 Cremation 3 Removal from State Crematory of Delamrva 10/14/2010 4 ☐ Donation 6 ☐ Other (Specify) Delmar, Delaware 21. Signature of Fureral Service Zeller Funeral Home, P. O. Box 3171 1212 Old Ocean City Road, Salisbury, MD 21802 Part . Enter the disease, or omplications hat caused the death. shock, or heart failure. List only one case on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** 1 RATORY CUTE disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** SP12 4710N NEUMONIA Sequentially list conditions If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): pnysician and the burial-transit Exami SEIZURE Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 NO 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home Certification: To 1 TYes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 🗹 Residence 6 ☐ Other (Specify) 27. Marvier of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 / Natural 1 ☐ Yes 2 Accident 2 🗌 No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit Division of Vital Records, P.O. Box 68760,

> State Registrar

31. Date filed (Month, Day, Ye

29a. Certifier (Check only one)

/Au21

29b. Signature and title of certifier

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KHALK

**ORIGINAL** 

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

21804

Amended Item Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

14 per F.D. 10/14/10 Carroll Co., will

State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day CHEN IESHEN Q 35 DCT Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Columbia Examiner 4c. County of Death Howard Howard County General Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Vietnam 8. Date of Birth **Funeral** 1 □ xM 2 □ F Months Days Hours Min. Year) 932 652-20-5372 78 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If tien 27 is marked other than "naturali", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Howard Columbia 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10209 MacGill Avenue 21044 USA 12. Was Decedent Ever in U.S.
Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced Asian 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) mechanical engineer engineering Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Zhaodin Chen Saiging Hu 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10209 MacGill Ave., Columbia, MD 21044 Xi Hui Li (spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 A Burial 2 Cremation 3 Removal from State Lake View Memorial Sykesville, MD 4 Donation 5 Other (Specify) 10-16-10 Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel Parge Haight Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ ARTERY CORONARY DISEAJE Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIAbers Mellitus Records, 1 Yes 2 No 3 Probably 4 Unknown hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 CEREBROUASCULAR performed? ACCIDENT 1 ☐ Yes 2 ☐ No Yes 2 No within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, Division of Vital Be ( 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00053150 WIL 067 Spuple MD SantiapoRd suite 110, (olvinbia 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shakunmala Gupta 9650 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	State of Maryla		artment of He tificate of De		/lental Hy	giene Reg. No	2010	34365
	Physicia		1. Decedent's Name (First, Middle, Last)					2. Date of De Month		2010	3. Time of Death
~	Medic Examin		4a. Facility Name (if not institution, give s		10.5	4b. City, Town, or L	- 0	CAUS	4c. 0	County of Dear	
and the	Funeral		5. Social Security Number 6. Sex 578-80-2118	7. Age (In yrs. 55	last birthday)	If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Bir	th Vear	g. Bir	thplace (State or Foreign
7	Director		Usual Residence of Decedent		113.		Hours war.	03/16/1	955	Ď	ountry) C
	aryland a-f show fied at	Director	10a. State 10b. County		City, Town or Local lashingt						10d. Inside City Limits 1X Yes 2 □ No
	the Ma a or 28a se notif	Dire	D. C. None  10e. Street and Number			10f. Zip Code			10g. Citiz	en of What Co	
	ath with	Funeral	2336 Payne Terrac	e, S. E.  12. Was Decedent Ever in U	IS 13 V	20020 Vas Decedent of Hisp		ocify Ves or No-		S. A.	day to the
3036	o filed within 72 hours after death with the Maryland that Hygiene. A other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at	Completed by Fi	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 ☐ Yes 2 K No If Yes, Give Year or Dates.	lf lf	Yes, specify Cuban,  Yes 2 X No	Mexican, Puerto	Rican, etc.)		4. Race - Ame Black, Whit pecify: <b>B1.</b>	e, etc.
Maryland 21215-0036	in 72 hou e. nan "nat Medica	omple	15. Decedent's Edu (Specify only highest grad Elementary/Seconday (0-12)		(Give k	ent's Usual Occupati kind of work done dur D NOT use retired) Ly-Care Pr	ina most of work	ing		d of Business	,
r 2 D	led with Hygien other the	Be C	12th 17. Father's Name (First, Middle, Last)		Da		8. Mother's Nam	e (First, Middle,	I	l.f-Emp]	Loyeu
ylan	ould be filed wit d Mental Hygie marked other matic event, th	ပ္	Johnnie Champion					Gaithe			
	2 shoth and the and th	59	19a. Informant's Name/Relationship (Typ Tamika Champion	e, Print) (Daughter)		g Address (Street and 1 Seventh			-	-	DC 20011
more	Page 1 and and ment of Heali ant: If item 2 ury or other		20a. Method of Disposition 1   → Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	Removal from State		sition (Name of natory or other place) Memorial	i	Date 6/2010		ation - City or	Town, State Maryland
galtimore,	permit. Pag Department Important: any injury c	9	21. Signature of Funeral Senice Librase			Name and Address H Bacon 47 14th S					
			23a. Part 1. Enter the disease, or complishock, or heart failure. List only one	cation that caused the dea						gton, 1	Approximate Interval Between
	h sician/ Medical	Š W	Immediate Cause (Final disease or condition resulting in death)	Pulmur- Due to (or as a conse	y Hy	zertensia	<u> </u>				Onset and Death
	Examiner	er	Sequentially list conditions,	Right ver	traila	heart	Fail	re			
Ī	uted Id ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to (or as a consec	quence of):						
2	icate be executed physician and s the burial-transi	edical Ex	resulting in death) Last	Due to (or as a consect Stage V	Sac	rel dece	bifus	)(ce/	_		
09/89	ding physe as th		IF FEMALE:	3c. If yes, outcome of prean	nancy	<u> </u>					
J. BOX	the death or by the atten- ached for us	Physician/N	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9  Unknown	3c. If yes, outcome of pregn 1 ☐ Live Birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3 f death 5	Ectopic pregnancy Other (specify)			20	3d. Date of de Month	livery Day Year
rds, P.O.	To the hospital or Attending Priysician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	by	Part II. Other significant conditions con	tributing to death but not re	esulting in the ur	nderlying cause given	n in Part I.				o the cause of death?
Heco	Ine law re cate has by page 2 sh	Completed						24a. Was autop perfo 1 □ Yes	osy rmed?	prior to death?	topsy findings available completion of cause of
VICAL	ysiciari. s certific director,	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No	ospital:	TER/Outpatient	Lau	e of Death (Check		tence 6	Other (Spec	sife)
DIVISION OF VITAL RECORDS,	eath. eath. or: After thi the funeral o	Certificate: T	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury a work?		28d. Describe h			ary)
	lo the Hospital of Attending within 24 hours after death. To the Funeral Director: After completed filled in by the funer	al Certi	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Specif		et, factory, office		28f. Location (S City or Tow		Number or Ru	ral Route Number,
1	in 24 hou in 24 hou ar Funer pleted fill	Medical	(Check 2 Medical Examine	cian: To the best of my know er: On the basis of examination Practioner: To the best of m	on and/or investi	gation, in my opinion,	death occurred at	the time, date a	nd place, a	nd due to the	cause(s) and manner stated.
ļ.	with com		29b. Signature and title of certifier	Posihe	ent Ohusie	29c. License ni	umber 1985		29d. Date	signed (Month	h, Day, Year)
	1		30. Name and address of person who cor	mpleted cause of death (Iter	m 23a) (Type, Pr	int)	e, MD	212	01	:Ilen	e Lowis
-	Stat Registra		31. Date filed (Month, Day, Year)  OCT 18 2010	32. Registrar's Signa	ature par	Ked	,			·	

Clark, Llaureen Onn

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		•	State of Maryla  State of Maryla  Amend Item l per dr., g	nd / D <b>;909 ,</b>	epartment of H 11/03/2010 d Certificate of L	lealth and N I <b>hb</b> Jeath	lental Hy	giene Reg. No.:	34366
	Physicia	n/			Clark	-	2. Date of Dea	ath Day Year	3. Time of Death
-	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Death	October	4c. County of Dea	
	ŕ		Sin ai Hospital of Balti				tx		
H	Funeral Director		5. Social Security Number $148-28-9752$	. last birtho	Months Days	If Under 24 Hrs. Hours Min.	8.'Date of Birt (Month, Da APTIL I	9. B 8, 1919 Okl	irthplace (State or Foreign ountry) ahoma
	yland f shov ed at	tor		*	or Location				10d. Inside City Limits
	r 28a- notifie	Director	Marylnad Washington County Hag	ersto	DWN 10f. Zip Code			40-00	1 🗆 Yes 2 🔀 No
	with the s 23a c ust be	Funeral I	11720 Pheasant Trail		21742			10g. Citizen of What C	ountry?
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	ह	11. Marital Status  1  Never Married 2  Married  3  Widowed 4  Divorced  12. Was Decedent Ever in UArmed Forces?  1  Yes 2 X No If Yes, Give Year or Dates.	.S.	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 X No	ın, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: Wh	ite, etc.
5-0	2 hour "natu edical	Completed	15. Decedent's Education (Specify only highest grade completed)	1 (0	ecedent's Usual Occup Give kind of work done of		ing	16b. Kind of Busines	s Industry
2121	led within 7 Hygiene. other than ent, the M		Elementary/Seconday (0-12) College (1-4 or 5+)		fe. DO NOT use retired) acher			Church Sc	hool System
pu	be filed v ental Hyg <b>ked othe</b> <b>c</b> event,		17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle,		
ryla	should be fil and Mental is marked or raumatic eve	입	George Bryant Sloan  19a. Informant's Name/Relationship (Type, Print)					Tyson Sloa	
	d 2 sho alth an 27 is ir traur		Robert B. Clark, Jrson	I .	Mailing Address (Street a				
Baltimore,	ge 1 and 2 It of Healt If item 2 or other	1	20a. Method of Disposition 20b.	Place of D	Disposition (Name of crematory or other place		Date	20c. Location - City of	
ţ	permit. Page 1 Department of Important: If i any injury or once.		4 □ Donation 5 □ Other (Specify) Gr		awn Mem. Pa	rk 10 <b>-</b> 1			
Bal	permi Depa Impo any ir		21. Signature of Funeral Service Licensee		C		0	Fiery Fun Magerstown.	
	Physician/	5 3	23a. Part 1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	ath. Do not	enter the mode of dyin				Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death)  a. Due to (or as a consecutive consecution)	uence of	1 1	+ .	1.	, , , , ,	Louys
	p #	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	uence of):	rotic h	earl (	MISEG	.se	unkhuwn
	e executed cian and urial-transit	al Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last c. Due to (or as a consecutive of the consecution of t	quence of):	:				
209	icate b g physia is the b	ledic	d						
. Box 68760	The law requires that the death certificate be rate has been signed by the attending physicipage 2 should be detached for use as the bu	Physician/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnant in the past 12 months?  4 ☐ Pregnant at time of 9 ☐ Unknown	tal death	3	у		23d. Date of d Month	elivery Day Year
, P.O.	es that the signed by be detaction		Part II. Other significant conditions contributing to death but not re	sulting in t	the underlying cause giv	en in Part I.		obacco use contribute t	to the cause of death?
ords	requir been s should	letec	Hypertension Hyperlipitemia				24a. Was		utopsy findings available
Reco	: The law cate has ; page 2	Completed by	11				autop perfo	prior to death?	completion of cause of
/ital	rsician: The certificate lirector, pag	To Be	25. Was case referred to medical examiner?  1  Yes 2 No  Hospital:  1 Inpatient 2	] EB/Outs	Othe	ace of Death (Checker:			-16.3
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completed filled in by the funeral director,	sate: T	27. Manner of Death  1 ■ Natural 5 □ Pending  28a. Date of injury (Month, Day, Year)	28b. Tim	ne of 28c. Injury	at :		lence 6 Other (Spe ow injury occurred	city)
visio	or Atten ifter deat irector: in by the	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At Inbuilding, etc. (Species)	ome, farm			28f. Location (S City or Tow	treet and Number or R	ural Route Number,
Ō	spital o		29a. Certifier 1 Certifying Physician: To the best of my know	wledge, de	ath occured at the time.	date and place, an	d due to the cau	use(s) and manner as s	tated.
	the Ho	Medical	(Check 2 Medical Examiner: On the basis of examination only one) 3 Certifying Nurse Practioner: To the best of m	on and/or ir	nvestigation, in my opinic	n, death occurred at	the time, date a	nd place, and due to the	cause(s) and manner stated.
	Voit To 1		29b. Signature and title of certifier	10	29c. License			29d. Date signed (Mon	
			30. Name and address of person who completed cause of death (Iter	m 23a) (Tvi		000		October	15 2010
ئ	4-7		Justin Mshaw, MD S	inai	4.4	of Bar	Timo		
	Stat Registra	e ir	31. Date filed (Month, Day, Year) 32. Rejistrar's Sign.	ature	base				
				100	7				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ WILBUR H. COSTER Medical October 2010 3:55 AM 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🔀 M 2 🗆 F 10/1/1925 Days Hours **Director** 216-28-8804 Maryland Usual Residence of Decedent 10a. State 10h County with the Maryland notified at 10c. City, Town or Location Director 10d. Inside City Limits 28a-f PA York Delta 1 🗆 Yes 2 🛱 No 5 10e. Street and Number 10f. Zip Code Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be I 10g. Citizen of What Country? Funeral 10 W. McKinley Road 17314 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 XMarried Armed Forces? Completed by Black, White, etc. 1 Yes 2 No 3altimore, Maryland 21215-0036 should be filed within 72 hours afte and Mental Hygiene. 'Is marked other than "natural", 1 ☐ Yes 2X☐ No Specify: 3 Divorced White Specify: Year or Dates WWII 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Farmer Agriculture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Henry Coster Margaret Winkler 0355 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred C. Coster/Wife 10 W. McKinley Road, Delta, PA 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Spenty) cemetery, crematory or other place St. Mary's Cem. 10/25/10 Pylesville, MD 21. Signature of ral Se 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ piration neumonia disease or condition Medical resulting in death) Due to or as a consequence of Examiner ementia Sequentially list conditions, if any leading to in a cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner M0000005986 Clinite for es a consultamente Rinsons resulting in death) Last Due to (or as a consequence of Physician/Medical Box 68760 use as 1 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ be detached for in the past 12 months? 1 Live Birth
4 Pregnant
9 Unknown Pregnant at time of death Month Day Yes 2 No the 9 Unknown Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ry artery Disease Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has after death.

Director: After this certificate | performed? Yes 2 No filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital 2 4 No 1 🗆 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0065827 10/21/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 19, 2010 **Physician** Clara Alverta Durst 10:20 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Frostburg Village Nursing Home Frostburg Allegany 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Jan. 29 Birthplace (State or Foreign Country) **Funeral** Months Days Hours Year. 1 □ M 2 1 F 216-32-1466 79 Maryland Director Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 ▼No Director MD Garrett Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Pages 1 and 2 should be filed within 72 hours after death with 635 Church Run Rd. 21532 USA "natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ģ Specify: 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene, Important: If Item 27 is marked other than "any inJury or other traumatic event, the Monee. Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Textiles 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alexander Martin Rowe Matilda Ann Beeman ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William F. Garlitz/Son 635 Church Run Rd., Frostburg, MD 21532 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Ann Cemetery Oct. 22, 2010 Avilton, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Newman Funeral Homes, P.A. P.O. Box 275, Grantsville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause Sinal disease or condition resulting in death) **Physician** UTFIMIERZ /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: 1 Yes 2 ₹No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27 Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Division of Vital Records, P.O. Box 68760, ours after death. ieral Director; Af filled in by the fur within 24 hours a

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harjit S. Sidhu, 925 Bishop Walsh Rd., Cumberland, MD

Hedh

and manner stated.

31. Date filed (Month, Day, Year) State Registrar

(Check only one)

29b. Signature and title of certifier

OCT 22 2010



29c. License number

126907

21502

29d. Date signed (Month, Day, Year)

OCTOBER 10 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State RegistramEND#20bperFH, 10/26/10, BMW.MOCO Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 Raymond Joseph Duncan 2214 M October Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Olney Montgomery General Hospital Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye June 30 7. Age (In yrs. last birthday) Funeral 9. Birthplace (State or Foreign 1 🛛 M 2 🗆 F Months Days Hours North Carolina Director Yrs 579-46-8352 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director 1 Tes 2 No Maryland Montgomery Silver Spring 10e Street and Number ö 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral U.S.A. 15444 Good Hope Road 20905 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 \( \subseteq \text{No } 1954 - \) Black White etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", traumatic event, the Medical Exar If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced 1962 White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Salesman Automobiles Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental F 7 is marked of ည Joseph Patrick Duncan. Jr. Sarah Mozelle Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If Item 27 is any injury or other trau once. 38012 Campbell Clan Lane, Purcellville, VA 20132 Mollie A. Brannon - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 10/2572010 1 🗓 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Maryland Vets Cem. <del>-10/15/2010</del> Crownsville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. MO # 1070 📲 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the distase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or bent till unable to list only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Anteriosclerotic Medical Due to (or as a consequence of) Examiner Sequentially list conditions, g physician and as the burial-transit if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 the attending phases the IF FEMALE: 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ secondary to aspiration Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Degenerative disease foint cate has page 2 s autopsy performed? death? certificate Yes 2 No 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? 1 Yes Other: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ မ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this n 24 hours after death.

e Funeral Director, After the leted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending 1 Yes 2 No ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town. State Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completed fi Defining Prijection. To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Olar Load Ct Olney Hayland F Wasdevard 3416 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Phy M Ex To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours often death Division of Vital Records, P.O. Box 68760

		Please	Type or Pri					re All Copie		_	
	1 - For State Registrar	e (First Middle I a			-	tificate of L		2. Date of D	Reg. I	2010	34370
an/ ical	Kur	t	W - 5	dug	1			Month 10	/13/	72010 Year	3. Time of Death 6:00 P M
ner	Klin	e Hospice				4b. City, Town, o	Airy			4c. County of Death Freder	ick
	5. Social Security N	9322	Sex 7. Ag	e (In yrs. lasi	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	4 Hrs. 8. Date of B (Month, L	ay, Year	9. Birti 913	hplace (State or Foreign intry) Germany
ctor	Usual Residence of 10a. State	10b. County		10c. City,	Town or Loc	ation					10d. Inside City Limits
Director	MD 10e. Street and Nur	Frede	rick	New	Mark	et 10f. Zip Code			100	Citizen of What Cou	1 Yes 2 No
Funeral	400 Ta	ilor St.				217	74		l log.	USA	and y :
þ	11. Marital Status 1  Never Marr	ied 2 🗆 Married	12. Was Decedent   Armed Forces?   1  Yes 2  If Yes, Give		If	as Decedent of H	ispanic Origir an, Mexican, I	n? (Specify Yes or No Puerto Rican, etc.)	)-	14. Race - Amer Black, White	, etc.
Completed	3 🖾 Widowed	4 Divorced  15. Decedent's E	Year or Dates.			ent's Usual Occup			401		ite
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10 B	17. Father's Name (	First, Middle, Last)  lm Dubin						's Name <i>(First, Middle</i> sa Bremer		en Surname)	
	19a. Informant's Na		Type, Print)		19b. Mailin	g Address (Street		or Rural Route Numb		or Town, State, Zip	Code)
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			Removal from State	cen	netery, crem	sition (Name of atory or other plac 1 <b>Cremat</b>		Date .0/14/2010	1	Location - City or Vinfield,	
	21. Signature of Fu	neral Service Licen	(any					uneral Ho erty Rd.,			•
	23a Fart 1 Enter t show, or hea Immediate Cause ( Isea or condition suring in death)	rt failure. List only o Final	plications tet caused one causeen each lind a.	d the death. e.	Do not ente	the mode of dyin	g, such as ca	ardiac or respiratory a	arrest,		Approximate Interval Between Onset and Death
	Sequentially list co	nditions,	b. Due to (or as	a consequer	oce of):	b'on					5-7 days
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dica			d								
Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ₽ 9 ☐ Unknown	months? Z No	23c. If yes, outcome 1  Live Birth 4  Pregnant a 9  Unknown	2 Fetal c	death 3 🗌	Ectopic pregnand Other (specify)	ру			23d. Date of deli Month	very Day Year
þ	A.F.	6	contributing to death b	out not result	ing in the ur	derlying cause giv	ven in Part I.			4	the cause of death?
Completed	Black	lder co	an cer					per	opsy formed?	prior to c death?	opsy findings available ompletion of cause of
Be	25. Was case referre	ed to medical				26. PI	ace of Death	1 \(\sum \) Yes (Check only one)	2/	No 1 L Yes	2 🗆 No
유	1 🗆 Yes 2	No		ent 2 🗆 Ef			4 ☐ Nurs	sing Home 5 Res			m Hospice
Certificate:	27. Manner of Deatl  1 Accident 3 Suicide	5 Pending Investigation 6 Could not be	00	y, Year)	8b. Time of injury						
	4 Homicide	determined	building, etc	c. (Specify)				City or To	wn, Sta		
Medical	(Check 2 only one) 3	☐ Medical Exam ☐ Certifying Nur	sician: To the best of iner: On the basis of e se Practioner: To the	xamination a	nd/or investi	gation, in my opinio	on, death occu	urred at the time, date	and pla	ce, and due to the ca	ause(s) and manner stated
	29b. Signature and	title of certifier	18/1	i	w	29c. License	number	4		Date signed (Month,	
			completed cause of d	,		•	) ( - 1 C	C+	02	M+ A = ===	, MD 21771

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year) OCT 1 4 2010

Registrar's signature

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year 0020 AM 17,2010 ohn chard Dierker October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner River Itoso; tal hester hestertown Kent 5. Social Security Number Age (In yrs. last birthday) 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 XM 2 □ F Months Hours Director 218-16-5229 03/24/1923 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examber to ust be nutitled at Director 1 X Yes 2 □ No MD Kent Rock Hall 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 20723 Mercer Avenue 21661 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates <u>م</u> Specify 3 Widowed 4 □ Divorced Specify. White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Restaurant/Service Sta. Store Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ John Richard Dierker Sr. Edna Gears 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Miller - Daughter 504 North Kent Street Chestertown, Maryland 21620 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Wesley Chapel Cemetery10/22/2010 Rock Hall, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. prateller 130 Speer Road Chestertown, Maryland 21620 23a fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** STAPHYLDCUCCAL disease or condition resulting in death) days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, I Try, I Ling L. Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.O. ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ sign be HEART 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown Be Completed completely filled in by the funeral director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate DIABGTES MELLITUS 2 000 Division of Vital 1 □Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No 24 hours after deatl Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 10-18-2010

Registrar

State

Name and address of person

RM

Box 68760, P.O. Records, Division or Vital

ne Hospital or Attending P n 24 hours after death. ne Funeral Director; After t the filled in by

To the within 2.

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD# 33255 OCTOBER 13, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KAREN ANN BLACKSTONE, M.D., VAMC, 50 IRVING STREET NW, WASHINGTON, DC 20422/688

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

Medica

31. Date filed (Month, Day, Year) OCT 18

4 Homicide



28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

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Runetta Kaye Fi		1- For State Registrar		ate of Ma	ryland		tment c			d Menta			g. No.	201	0 3	437
Physicia Medical Examii		1. Decedent's Nam Runetta	Kaye	Fiel	Ld						Mo	onth ctober 19	Day	Year 0	3. Time of E 1444 h	
		4a. Facility Name (i		n, give street an rial Hospital				4b. City, T Oakla		Location of I			4c.	County of Dea arrett	th	
Funeral Director		5. Social Security N		6. Sex		e (In yrs. last	t birth <b>d</b> ay) Yr	Months	r 1 Year Days		Min.	Date of Birt		PD/YYYY) 9. B Fore C		
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nore, MD 21215-0036 sges I and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. tt: If item 27 is marked other than "natural", or items 23a, or 28a-f show any other traumatic event, the Medical Examiner must be notified at once.	Completed	Elementary/Seco	ondary (0-12)	Colleg	ge (1-4 or 5	5+)	•	nost of work		DO NOT us	e retired)		G	rocery		
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e, MD I and 2 sho Health and item 27 is		Teresa Ha		sister						at Roa			•			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		20a. Method of Disp 1 Donation 5	Cremation		al from Sta	ate cre	ce of Dispo matory or o and C	ther place) cemete	ry	1	Date 0/23/	2010	0a	kland,	MD	
Balti Sermit. Departr Import	Ī	21. Signature of Fu	neral Service	Licensee	2-6		22.	Name and	Address	of Facility D	avid	A. Bu	ırdo	ck Fune	eral Ho	me P.
Physician	+	23a, Part I. Enter th			nat caused	the death. D	- 4	T TA*	ZIIU	St, U	akıan	u, m	Z I.	J J U	Approxima	ate Interval
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Box 68760, re death certificate be the attending physic red for use as the burned for us	Physician/Medic	past 12 months  1 Yes 2 N		4 P		time of death	=	ther (Special	-				"		zay	, cai
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial	Completed by										-	4a. Was ai autops perform Yes 2	y ned?		utopsy findings completion of es 2	
Vital Rec ysician: The I his certificate I director, page	Bec	25. Was case refer	ed to medical					2		of Death (Ch						
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Division pital or Attendir ours after death. teral Director: A	Certification:	3 Suicide 4 Homicide		not be 28e. I mined (Spec		ury - At home	e, farm, stre	et, factory,	office bu	uilding, etc.		ocation (St r Town, Sta		d Number or R	ural Route Nu	nber, City
To the Hospital within 24 hours To the Funeral completely filled	Medical			ysician: To the niner:On the ba and mann	sis of exan											
F # F S	ĕ	29b. Signature and	title of certifie			_	1	29c.	License					ate signed (Mo		)
	-	30. Name and addre	ess of person	who completed	cause of de	eath (Item 23	(a)		O.C.M	n.E.	OCME		Octo	ber 20, 201	· · · · · · · · · · · · · · · · · · ·	
	5	Theodore M	. King, Jr.,			edical Exa	•	111 Pe	nn Stre	eet, Baltin	more, MD	21201				
Sta Regist		31. Date filed (Mont.	h, Day, Year) 2.5.20		. Registrar	's Signature	back	1								

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 09:02 Regina Lawler Fox October Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Union Hospital of Cecil County E1kton Ceci1 If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year 7. Age (In yrs. last birthday)
67 yrs. 9. Birthplace (State or Foreign County) Ooklyn
New York Funeral Social Security Numbe 6. Sex 1 ☐ M 2 💢 F 219-42-6546 Director New Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If teem 27 is anarked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Ceci1 E1kton 1XXYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 150 East Main Street, Apartment 313 21921 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Assembler 4 8 1 Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ralph Edwin Fox Regina Gertrude Lawler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosemary Fox / Daughter 65 Yellowfield Boulevard, Elkton, Maryland 21921 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State October cemetery, crematory or other place) 4 Donation 5 Other (Specify) 20, 2010 Mayerdale Crematory Newark, Delaware 21. Signatur of Junear Service Ansee 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ MYOCARDIAL INFARCTION disease or condition MINUTES Medical resulting in death) Examiner ANEMLA HOURS Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit WEEKS FAILURE ACUTE RENAL Due to (or as a consequence of) resulting in death) Last Physician/Medical HYPERTENSION YEAKS Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth
4 Pregnant a
9 Unknown in the past 12 month 3 Ectopic pregnancy Dav Year 5 ☐ Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No After this certificate has 1 TYes 2 1100 1 Yes **Director:** After this certific I in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending injury 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) NTTHOOD OCTOBER 15, 2010 ハり 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SWITE #3 ELHTON MANYLAND DAVIN 304-306 NORTH STREET GALTEL Registrar's Signatur Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34375 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2010 October 10, Regina Elizabeth Flaherty 10:43 p Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital Olney Montgomery Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth Funeral 1 □ M 2 🟋 F Months Days Hours June 27. 1920 029-09-1738 Director 90 Usual Residence of Decedent 3a or 28a-f show be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🏋No MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral **Examiner must** 15100 Georgia Avenue USA items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Armed Forces Black, White, etc. Hygiene. other than "natural", or i Page 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or ğ 1 Never Married 2 Married 1 ☐ Yes 2 😿 No If Yes, Give 1 Yes 2 TrNo Specify Specify: White Completed 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 12 Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Robert Jennings Helena Coulette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Vincent Flaherty/Son 15100 Georgia Avenue, Rockville, MD 20853 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State metery, crematory or other p Lington National Cemetery 1 A Burial 2 Cremation 3 Removal from State Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service H 22. Name and Address of Facility Francis J. Collins 500 University Blvd. Funeral Home Inc. W., Silver Spring, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a d **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed 100 that initiated events Due to (or as a consequence resulting in death) Last attending physician Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Dav 1 ☐ Yes 2 ☐ No 9 ☐ Unknown signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has be lirector, page 2 s autopsy performed Yes 2 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes 2 No မှ I Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5  $\square$  Pending Natural 24 hours after death. E Funeral Director: Aft leted filled in by the fur work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 only one 29b. Signature and title of certifi 29c. License number 29d, Date signed (Month, Dav. Year) H63192 OCTOBER 11 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

SHAWN TWEEDT

5 2010

31. Date filed (Month, Day, Year)

21215-0036

Box 68760

P.O.

Records,

of Vital

Division

PHILIP

DRIVE, STE T-12,

20832

PRINCE

18111

2. Registrar's Signature

10-07887		Pleas		e or Print i								.egik	ole.		
Steven Wilfred I	Foc.	ht		ate of Maryl	and / De	partment o	of l	Health a					20	10	34371
		1- For State Registrar	_		С	ertificate (	of L	Death				Reg. N	No.	10	0401
Physicia Medical Exami		1. Decedent's Name (F									2. Date of D Month October	Da	y Year		3. Time of Death 0023 hrs
		Steven W 4a. Facility Name (if no			umber)		4b.	. City, Town,	or Loca	tion of Death		17, 2	4c. County of	f Death	<u> </u>
Ha.		1511 Pilgrim L	Lane					Finksburg					Carroll		
Funeral		5. Social Securify Num	mber	6. Sex	7. Age (In yr	s. last birthday)		If Under 1 Ye		Under 24Hrs	_	Birth(N	M/DD/YYYY)	9. Birt Foreig	hplace (State or
Director		217-76-9234	4	1 M 2 F		_48 _ Y	rs.	Months Da	ays   F	Hours Min	03/18	/19	62	Cou	untry) MD
ŕ		Usual Residence of De 10a. State 10t	ecedent b. County		100.0	ity, Town or Loc	ation								
1. T			,			•	ation								10d. Inside City Limits 1 Yes 2 No
rylanda-franta-f	ctor	MD C 10e. Street and Number	Carro er	<u> </u>	Fi	nksburg	11	I0f. Zip Code				10a (	Citizen of Wha	at Cour	
he Ma or 28	Director	9E11 D:1	T									l .eg. v		ooan	,.
with t 18 23a		1511 Pilgr 11. Marital Status	CIM La		cedent Ever in	ı U.S.   13. W		21048 Decedent of H	lispanio	Origin? ( Sr	pecify Yes or	No-	U_S_A 14. Race -	Americ	can Indian, Black,
death r iten	uneral	1 Never Married	2 XMa	Armed F	orces?	If		specify Cuba					White,		<b>,</b>
after	by F	3 Widowed	4 Dive	orced If Yes, Give Ye or Dates:			] Y	es 2X N	lo spe	ecify:			Specify:	Whi	ite
hours natur Exam	ed	15. Decedent's Educa						Usual Occup				16t	. Kind of Bus	iness/Ir	ndustry
36 in 72 han "	Completed	Elementary/Seconda	ary (0-12)	College (	1-4 or 5+)						,				
5-0036 fled within 7 Hygiene. I other than	МÓ	17. Father's Name (Fire	rst, Middle.	Last)		Elect	ri	cal Te	Ch 18.Ma	other's Name	(First, Middle	• Maide	Mass 1	rar	sit Admin.
215 be file ttal Ho ked o	Be	Wilfred Jo		·							ienert	, , , , ,	on our junto,		
2121 ould be fi d Mental s marked iic event,	To	19a. Informant's Name	/Relationsh	nip (Type, Print )		19b. Maili	ng A	ddress (Stre	et and	Number or F	Rural Route N	umber,	City or Town,	State,	Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Donna Foch		e		1511	Ρi	lgrim	Lan	e. Fir	ıksbur	1. N	4D 2104	18	
ore, s 1 an of Hea of Hea or tr		20a. Method of Disposi		3 Removal fi		b. Place of Dispo crematory or o			emeter	y	Date	20	c. Location - (	ity or 1	Town, State
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Balt permit. Departu Import injury		21. Signature of Funera	al Service	icensee		22.	Nam	ne and Addres	ss of Fa	cility Pri	itts F	ıner	al Hon	ne &	Chapel, P
Physician		23a. Part I. Enterthe di	lisease or o	complications that	aused the dea	41	.2 the r	Washin	igto	n Roac	d, West	mir	ster,	MD	21157 Approximate Interval
/Medical		failure. List only o	one cause	on each line.			1101	mode of dying	, suon	as caldiac of	i respiratory a	iiicsi, s	niock, or riear	,	Between Onset and Death
Examiner	I	Immediate Cause (Fina or condition resulting in		a. Multiple Gu										-	Death
		Sequentially list conditi	tions,	b											
	Examiner	if any, leading to immed cause. Enter Underlyin		Due to (or as a	consequence	e of):								ļ	
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Box 68760, death certificate be he attending physic d for use as the buri	Ž	IF FEMALE: 23b. Was decedent preg	gnant in the	23c, If yes,	outcome of pre		otal	death 3	Fr	topic pregna	nev	2	3d. Date of de Month	elivery Da	av Year
OX 687 eath certification attending for use as t	icia	past 12 months?		4 Pregn	ant at time of	dooth -		(Specify)		topio progridi	1109		World	0.	sy Teal
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of Vital Records, P.O. E ag Physician: The law requires that the d ther this certificate has been signed by the meral director, page 2 should be detached	집	Part II. Other significan	int conditio	ons contributing to	death but not	t resulting in the	unde	erlying cause	given i	n Part I.			o use contribu	_	ne cause of death?
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COF law re has be	Completed						-				auto	opsy formed	prid		mpletion of cause of
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n of Vi ding Physi After this funeral dir	<u>۱.</u>	1 ✓ Yes 2 2 27. Manner of Death	No	28a, Date	of Injury	28b. Time of							njury occurred		Scerie
on endin ath.	틝	1 Natural 5			2010 2010	0015 hrs		1	Yes 2	✓ No	Subject sh	ot			
Division sal or Attendii rs after death. al Director: A	ifica	2 Accident 3 Suicide 6		igation not be28e. Place	e of Injury - At	home, farm, stre	et, fa	actory, office I	building	g, etc.			and Number	or Rura	al Route Number, City
Divi	Certification:	4 V Homicide	detern		Outside r	esidence					or Town, I511 Pilgrim	Lane,	, Finksburg,	MD	
the Hos hin 24 h the Fur	Medical			vsician: To the bes	of examination										
To To COM	Me	29b. Signature and title		and manner s	ated.			29c. Licens					. Date signed		
WJL		(0)	, 1	HAND	0 0			O.C.	M.E.				tober 14,		
201A	-	30. Name and address of	of person v	ho completed caus	e of death (Ite	m 23a)									
		Carol Allan, MD		stant Medical I		111 Penn	Stre	et, Baltim	ore, M	MD 21201					
Ste	31.0	31. Date filed (Month, Da	Day, Year)	32 Re	gistrar's Signa	ture									

Registrar

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 920 Jane C Fisher Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WMHS-RMC Cumberland Allegany Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1 🗆 M 2 🖵 F Hours Min Month, Day Apr 2 <sup>Year)</sup>933 Director 214-32-8215 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Xes 2 No Allegany Cumberland 10e. Street and Numbe 10g. Citizen of What Country? 707 Montgomery Avenue 21502 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) RN Hospital traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Howard Lester Schaffer Maragaret Elizabeth Morgart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau J<u>eff Fisher</u> Son <u>707 Montgomery Avenue Cumberland</u> MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/21/201b arpelli Funeral Home, P.A MD Cresaptown 21. Signature of Funeral Service Liçensee 22. Nam Scarpelli Furieral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 7. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence on. and I-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician (for use as the burial-Physician/Medical Division of Vital Records, P.O, Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Month Year been signed by the sahould be detached a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed' 2 1 No certificate Yes 2 1 Yes 25. Was case referred to medical director. Be 26. Place of Death (Check only one) examiner? Hospital 1 Tes 2 No Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one

DHMH 17 Rev 7/2009

State Registrar

certifier

Shiv Khanna

31. Date filed (Month, Day, Year)

29b. Signature and title

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

1221 F. National Highway LaVale MD 21502

			For State	State of M	aryland / Dep	artment of rtificate of		and N	/lental Hy	giene <sub>20</sub>	10	3437	19
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	Physicia Media		Dennis Gerald	. ,					Month	Day	Year	3. Time of Dear	ith M
-	Examir		4a. Facility Name (if not institution	,		4b. City, Town,		of Death		4c. County			
	<i>'</i>		WMHS Regional  5. Social Security Number			Cumberl				Alle			
	Funeral Director		213-50-7907	6. Sex 1 <b>X</b> M 2 □ F	e (In yrs. last birthday)  58 Yrs.	Months Days		24 Hrs. Min.	8. Date of Birl June 1.	ž <sup>, Yea</sup> /1952		place (State or For Y <b>1an</b> d	eign
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	the N		10e. Street and Number		7	10f. Zip Code				10g. Citizen of W	/hat Cou	ntry?	
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	riten inerr		11. Marital Status	12. Was Decedent E Armed Forces?		Was Decedent of If Yes, specify Cub	Hispanic Origon, Mexican	gin? (Spe , Puerto	cify Yes or No- Rican, etc.)		- Americ	can Indian,	
21215-0036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho er the Medical Examiner must be notified at	Completed by	1 ☐ Never Married 2 🛣 Marri 3 ☐ Widowed 4 ☐ Divorced	ied 1 ☐ Yes 2 🗶 If Yes, Give Year or Dates.		1 ☐ Yes 2 🛣 N	o Specify;			Specify:	Whi		
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9	led will Hygid other ent, t	Be (	17. Father's Name (First, Middle, L	ast)	I Count	<u>y Commis</u>			e (First Middle	Govern  Maiden Surname)			
Maryland	should be filed within 72 h and Mental Hygiene. 7 is marked other than " rraumatic event, the Mec	မှ	Gerald Glotfelt	У					ollier	Maiden Gamame)			
lan.	shoul and l is ma	6 8	19a. Informant's Name/Relationsh	ip (Type, Print)	19b. Maili	ng Address (Stree	t and Numbe	r or Rura	l Route Number	r, City or Town, St	ate, Zip (	Code)	
e,	and 2 Health tem 27		Sandra L. Glotf 20a. Method of Disposition	elty/Wife		Box 202	, McHe	enry	, MD 2.	1541			
Baltimore,	- # E 2		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		20b. Place of Dispo cemetery, crer Flatwoods	natory or other pla			<sup>Date</sup> 25, 20	20c. Location - (	•		
Balt	permit. Page Department of Important: If any injury of once.		21. Signature of Funeral Service L	S Jerman	/	. Name and Addr				neral Ho	mes, 536	P.A.	
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289	ertifica ding p	/Me	IF FEMALE:	23c. If yes, outcome of	of pregnancy								
ROX	eath ce attene	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No		2 Fetal death 3	Ectopic pregnan Other (specify)	су			23d. Date Mont		ery Day Year	
O.	the de by the	hys	9 ☐ Unknown	9 Unknown									
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DIVISION OF	ding Ph h. After thi funeral	Certificate: 1	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of injun (Month, Day,	y 28b. Time of	28c. Injur	v at	2		ow injury occurred		<u>'</u> -	
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2	ital or urs afte ral Dir lled in			building, etc.					City or Town		_	·	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 $\square$ Medical Ex	Physician: To the best of n caminer: On the basis of ex Nurse Practioner: To the b	amination and/or invest	gation, in my opini	on, death occ	curred at t	the time, date an	d place and due t	o the cau	se(s) and manner of	tated.
	vith Volume		29b. Signature and title of certifier	Padu	,	29c. Licens	e number			29d. Date signed (			
		-	20 Name and address	1 Juni	<u> </u>		6341	62		10/2	1/	2010	
		0	30. Name and address of person w Alida Podrumar,				11ta 3	nn .	Cumberl	am Dae	215	502	
1,4	Stat	e	31. Date filed (Month, Day, Year)	32, Registrar	's Signature		ALCE J	557	CUIIDELI	ana, Pi	21-	,UZ	
	Registra	r	OCT 22 2	010 /2	. A be	Kel							

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State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar			ertificate of			g. No.		3,000
			1. Decedent's Name (First, Middle, La	ist)	11	<u> </u>		2. Date of Death	1	Vasa	3. Time of Death
	hysici Medic		Rawaie	C. (	Billum			/ O	Day 16	Year 2010	1:20 A M
	xamir		4a. Facility Name (If not institution, give	e street and number)	•		or Location of Dea	ath	4c. County		1.7
•			162 Main Street				sville		Gar	nett	-
	neral ector		1110 00 0,00	Sex 1□M 2½TF 7. Ag	e (In yrs. last birthd 2 Yrs	Months Dave	If Under 24 Hr Hours Mir		<sup>Year)</sup> 1938	Count	ace (State or Foreign try) ISYlvania
and	-		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10	Od Jacida City Limite
e Maryl	iffeda	ctor	MD Garret	t	Grantsv						od. Inside City Limits 1   Yes 2  No
ath with the	on ad tau	ral Director	10e. Street and Number 162 Main Street			10f. Zip Code 2153	36	. 10	g. Citizen of V USA	Vhat Count	try?
1215-U036 ithin 72 hours after death with the Maryland ne.	the Medical Examiner must be notified at	d by Funeral	11. Marital Status 1 □ Never Married 2 → Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1  Yes 2 1 ft Yes, Give Year or Dates:		3. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 🛛 No		Specify Yes or No- rto Rican, etc.)		e - America k, White, e	
ָה בְּר בְּר	dical	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. De	cedent's Usual Occupive kind of work done	ation during most of we	orkina 1	6b. Kind of Bu	siness/Ind	ustry
within 72 Boe.	# Me	Idu	Elementary/Secondary (0-12)	College (1-4or 5	+)	ive kind of work done  DO NOT use retire	d)	s.r.ig			
200	H.	ပိ	12 th 17. Father's Name (First, Middle, Last,		Hom	emaker				wn Ho	me
	• A	Be						ame (First, Middle, M		e)	
M M	natic	오	Charles H. Cramer		100			ne V. Wels			
Mal d2st th and 7 te n	traur		19a. Informant's Name/Relationship ( Ronald C. Gillum,			ailing Address (Street					
Heal	other		20a. Method of Disposition	Tiusballu		Main St., sposition (Name of rematory or other place		-	Oc. Location -		
Pages Pages nent of	y or c		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif			rematory or other place. Side Crem		7, 2010			
Caltimore, permit. Pages 1 ar Deportment of Hea	any injury or other traumatic	j	21. Signatura of Funeral Service Licer		Council	22. Name and Addre					
<b>n</b> && <u>E</u>	<b>≅</b> 8		1 Didynio	Jumo	u/ 1	79 Miller	St., Box	275, Gra	ntsvil	le, M	D 21536
t. 15°			23a. Part1. Enter the disease, or com shock, or heart failure. List only	pfidations that caused one cause on each lir	the death. Do not e.	enter the mode of dyir	ng, such as cardia	ic or respiratory arre	st,		Approximate Interval Between
Physic			Immediate Cause (Final disease or condition resulting in death)	a	104 stive	Haut	- Falu	SE			Month (
/Mec Exam			resulting in death)	Due to (or as	consequence of):						100
1	2. 2.	er	Sequentially list conditions,	b. Dus to for as	WENCE UN	Cardio	mychati	77			1 Chy's
uted	ansit	Examin	Sequentially list conditions, if any, reading to infriedrate cause. Enter Underlying Cause (Disease or injury that initiated events	,	, , , , , , , , , , , , , , , , , , , ,		171 17				
exec an an	as the burial-transit	Exa	resulting in death) Last	Due to (or as a	a consequence of):						
ficate be e	ing et	Medical		d							
rtifica ng ph	as t	Ved	IE ECMAN E								· ·
The law requires that the death certificate be executed attends been signed by the attending physician and	should be detached for use	Physician/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ™No 9 □ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetaf death	B □Ectopic pregnancy □ Other (specify)	,		23d. Date Mon	of deliver	y Day Year
that sed b	e deta	by Pr	Part II. Other significant conditions of	ontributing to death bu	it not resulting in the	underlying cause(giv	en in Part I.	23e. Did toba	icco use contri	bute to the	cause of death?
en sign	od bluc		Chanic	= Sfage	DK.	drex di	SCASC_	1 ☐ Yes	2 🗆 No	3 Proba	bly 4 Unknown
ne taw r	CV	Completed	Hrost	CASICA		0		24a. Was an	24b. W	ere autops	sy findings available
The The	page	5 F	Atrial	E. Jack				autopsy performe	ed? d	eath?	pletion of cause of
cian: entific	octor,	Be (	25. Was case referred to medical examiner?	7 777			26. Place of De	ath (Check only one)	2		
hysic this or	al dire	ု	1 ☐ Yes 2 🙀 No	Hospitaf: 1 ☐ fnpatier		ent 3 DOA Oth	er: 4 Nursing H	Home 5 ₩ Residen	ce 6 □Othe	r (Specify)	
Ing P	unera	ö	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of fnjur (Month, Day	Year) 28b. Time		y at k?	28d. Describe how	injury occurre	d	
Attending Physician: r death.	the f	cat	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □No				
s after of all Direct	ad in by	Certification:	4 Homicide determined	28e. Pface of Infu building, etc	ry - At home, farm, : . (Specify)	street, factory, office		28f. Location (Stre City or Town,	et and Numbe State)	r or Rural	Route Number,
To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha	etely filt	edical (	29a. Certifier 1 Certifying Phr (Check only one) 2 Medical Exam	ysician: To the best of iner: On the basis of and manner stat	examination and/or	ath occurred at the tin investigation, in my o	ne, date and place pinion, death occu	e, and due to the cau urred at the time, dat	ise(s) and mar e and place, a	ner as stat	ted. he cause(s)
o the	dEo	Me	29b. Signature and title of certifier	and mariner star		29c. License	e number	290	d. Date signed	(Month. Di	ev. Year)
r- 5 ⊢	0		· //h] ///			0 /-	70.0	200	1.1	,	-,, , , , , ,
		-	30. Name and address of person who	completed cause of de	ath (Item 23a) (Typ.	Print)	985		10/16/1	P	
		3	Chiede	A J.C	( M)	20	125/2 41	16 1 C	Vilcle.	) 11	1/ 2108.
	Stat	<b>-</b>	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	/11 /	VA. A.	718/1	-11-1M	1,10	Line a 110

DHMH 17 Rev 1/2001

ORIGINAL

Division or Vital Records, P.O. Box 68760 the Hospital or A

> State Registrar

DHMH 17 Rev 1/2001

(Month, Day, Year)

CHAN

29b. Signature and title of certifier

Audrey J.



Juhns Hopkins

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

29c. License number

Bayviews NEO, car Cente

29d. Date signed (Month, Day, Year)

,15,2010

4940 Eastern Ave. Baltimore MD.

OCTUGER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 9 Day 2010 Year 11:20 A<sub>M</sub> Physician/ Nathan Gordon Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Montgomery Bethesda Suburban Hospital 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Age (In yrs. last birthday) 6. Sex 1 → M 2 □ F **Funeral** Hours Days Min. Selfonth, Paz, Year 1917 Country) 93 New York 132-01-4993 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State death with the Maryland Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 X Yes 2 ☐ No Chevy Chase Montgomery MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20815 Funeral 8100 Connecticut Avenue #1423 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Armed Forces?
1 → Yes 2 → No 1943 1 Never Married 2 Married by Maryland 21215-0036 hours after 1 ☐ Yes 2 🔀 No Specify: If Yes. Give 1946 White 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) uth and Mental Hygiene. 27 is marked other than "r r traumatic event, the Med College (1-4 or 5+) Elementary/Seconday (0-12) Chemistry Chemist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Surname) Clia Tunick ೭ Morris Goldberg permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marker any injury or other traumatic e 20814 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4550 Montgomery Avenue Suite 775N. Bethesda, Maryland Marc Feinberg/Attorney Baltimore. 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place)
Mt. Lebanon Cemetery Adelphi, Maryland 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 10/12/2010 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Addr Partizeinsky-Goldberg Memorial Chapels, Inc. 21. Signature of Funeral Service License MCGHERNIO 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ Sepsis disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Acute Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter U. Jerlying Due to (or as a consequence of) Examine D. Cause (Disease or linjury Cardiomyopathy that initiated events resulting in death) Last attending physician and for use as the burial-tra Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy Month Dav in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death \_\_ Yes □ Unk been signed by the should be detached 9 Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? GORDON, NATHAN 2 1 Yes 2 XNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a Was an autopsy performed prior to completion of cause of has page 2 1 ☐ Yes 2 ☐ No Yes 2 No certificate To the Hospital or Attending Physician: within 24 hours after death.
To the Funeral Director: After this certific completed filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 🔀 No Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 🛚 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check wedlear examiner. On the pass, to examine the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title cause of death (Item 23a) (Type, Print) MD 8600 Old Georgetown Road, Bethesda, Maryland 20814 Natasha Prtina Halg

State

Registrar

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 14, October. 4:30 am 2 0 1 0 Ruth Sirota Gilder Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Asbury Methodist Home Gaithersburg Montgomery 5. Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign New York 1 M 2 X F Months Days Hours 09/15/1918 Director 577-20-4625 92 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Ves 2 No Maryland Montgomery Gaithersburg 10e. Street and Numbe 10f, Zip Code 10g. Citizen of What Country? Funeral 8 Manette Street 20878 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🗶 No Baltimore, Maryland 21215-0036 1 Tes 2 X No Specify: If Yes, Give Specify: 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Business Owner Jewelry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Isidore Sirota Pauline Greenberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark A. Gilder - Son 12205 Galesville Drive, Gaithersburg, MD 20878 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕱 Burial 2 🗆 Cremation 3 🕏 Removal from State King David Mem. Grdns: 10/18/2010 | Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home. 11800 New Hampshire Ave.. Silver Spring. MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Pnysician/ Myocardial Infarct disease or condition resulting in death) minutes Medical Due to (or as a consequence of) Examiner Atherosclerosis Heart Disease Years Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Live Earlie Live Birth 2 Live Bregnant at time of death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Multiorgan Failure Completed 1 Yes 2 No 3 Probably 4 X Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? Peripheral Vascular Disease page 2 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: 25. Was case referred to medical To Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 🕅 Nursing Home 5 🗌 Residence 6 🗌 Other (Specify) 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending iniury 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined 24 hours Medical 29a. Certifier Pertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one 29b, Signature and title 29c, License number person who completed cause of death (Item 23a) (Type, Print) 30. Name and address Suite 202, Gaithersburg, Maryland 20878 Turi 10810 Darnestown Road. Raman 31. Date filed (Month, Day, Year) 32 Registrar's Signatur State 15 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 34384 Certificate of Death Reg. No.-3. Time of Death 2. Date of Death ble x 2010 4c. County of Death Facility Name (If not institution 4b. City, Town, or Location of Death roster-town If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 4/18/1928 9. Birthplace (State or Foreign Country)
New Jersey 7. Age (In yrs. last birthday) Months Min M 2 🗆 F 577-40-8643 82 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1∏Yes 2∏No Maryland Montgomery Bethesda 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 5406 Spangler Ave 20816 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Architect U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert B. Garrabrant Elizabeth Ady 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Bayard Garrabrant II 23381 Hosta Lane California, MD 20619 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Chesapeake cremation ctr 10/16/10 Chester, MD 4 Donation 5 Dother (Specify) -22 Name and Address of Facility Fellows, Helfenbein & Newnam 130 Speer RD Chestertown, MD 21. Signature of Funeral Service Licensee art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) INTESTINAL IS CHEAMIA HOURS Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24a. Was an

Physician /Medical Examiner

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
24 hours after death.
24 hours after death.
25 After this certificate has been signed by the attending physician and attend of the content of the present of the page 2 should be detached for use as the buriah-transit

sate has been signed by the page 2 should be detached

Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

ral", or items 23a or 28a-f shov Examiner must be notified at

'natural", or

permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. important: If item 27 is marked other than "natur any injury or other traumatic event, I'm Medical once.

Director

Funeral

Completed by

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Examine

Physician/Medical

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Completed

Be

Certification: To

Medical

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Ener or deriving Cause (Disease or injury that initiated events resulting in death) Last

1 □Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 ☐ Yes

25. Was case referred to medical 1 Yes 2 No 27. Manner of Death

Hospital: 28a. Date of Injury (Month, Day, Year)

1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Natural

2 Accident

3 ☐ Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

STREET, CHESTERTOWN,

29b. Signature and title of certifier Flamen

MD

D0066441

2010 OCTOBIER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nu

RAMESH

5 Pending

investigation

6 Could not be determined

100 BROWN 32. Registrar's Signature

State Registrar

within 24 hours a

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 16, 2010 Evelyn Ruth Hetrick 12:30 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death South River Health & Rehab. Center Edgewater Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 6. Sex 9. Birthplace (State or Foreign **Funeral** Months Days Min. 1 🗆 M 2 😾 F June 23, Pennsylvania 1917 **Director** 93 200-28-8300 Usual Residence of Decedent items 23a or 28a-f show ner must be notified at filed within 72 hours after death with the Maryland al Hygiene. 1 other than "natural", or items 23a or 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🛣 No MD Calvert Owings 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20736 1940 Appaloosa Way USA n "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 1 Yes 2 No Black, White, etc. <u>Ş</u> 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Completed 3 X Widowed 4 Divorced Specify: White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Homemaker Own Home permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injuy or other traumatic even once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Clarence E. Durst Edith Susan Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13026 Harford Rd., Hydes, MD Rebecca Turner/Granddaughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Springs Cemetery Oct. 22, 2010 Springs, PA 21. Signature of Funeral Service License 22. Name and Address of Facility Newman Funeral Homes, P.A. P.O. Box 275, Grantsville, MD 21536 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ therosciemotic (ardio vasculas direcu disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) physician and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Completed by Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕦 No 5 Other (specify) Month Dav Year Pregnant at time of death 1 Yes 2 Ly 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Pneumonia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown congostive Heast Failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed' Advonce certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 🖪 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 Natural 2 Accident 3 Suicide 4 Homicide 5 $\square$ Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 3

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

5851

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deale.

Maryland 21215-0036

Baltimore,

Box 68760

of Vital

Division

Churchten

29c. License number

D-50653

Rd. Deale-

GYAN C. SURANA

29d. Date signed (Month, Day, Year)

10-20-10

1. December States (First, Asson, Last)   Dor's E. Coulse Harrigan   20 to 0 32.				For State Registrar	State of	Maryland / Depa	artment of F rtificate of		d Mental Hy	giene Reg. No.	10	34386
Dot's Louise Harrigan  Examinar  A family Name of the manuface of generated and manual a					ast)					eath	.,	3. Time of Death
4. Service Name of Country of Death  As Broilingsworth Manor Road 3  B. Scotian Status To Death  As Broilingsworth Manor Road 3  B. Scotian Status To Death  As Broilingsworth Manor Road 3  B. Scotian Status To Death  As Scotian Status To Death  As Scotian Status To Death  B. Scotia				Doris Louise H	arrigan					r 19 20		03:20 AM
December   December	Market					ber)	4b. City, Town, o	r Location of D	eath	4c. Count	y of Death	
OTT-20-0999   Image: Sept.   Boundary   Bo	u.				Manor R	oad 3					<b>i</b> 1	
Text   Section   Text				071-20-0999					in. (Month, D	irth Bay, Yea <i>r)</i> 3,1926	De	place <i>(State or Foreigi</i> er Park yland
Frank Lincoln Murphy   Section   S		and				10c. City, Town or Lo	cation					10d. Inside City Limits
Frank Lincoln Murphy   Section   S		f shc	ō	Manufand Coail		E11-6						1 ∐ Yes 2 <b>XX</b> No
Frank Lincoln Murphy   Section   S		the 1	rec			EIKU				10g. Citizen of	What Cou	ntry?
Frank Lincoln Murphy   Section   S		3a ol	교	48 Hollingsworth	Manor R	oad 3	21921			United	Stat	es
Frank Lincoln Murphy   Section   S		death	ner		12. Was Deced	lent Ever in U.S. 13.	Was Decedent of H	lispanic Origin	(Specify Yes or No			
Frank Lincoln Murphy   Section   S	9	or ite	교		1 □Yes 2	2 <b>X</b> No			Jerio Mican, etc./			-
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Physician (Modical Examiner)   Part				23a. Part 1. Enter the disease, or com	pplications that cau	used the death. Do not ent					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Approximate
Due to (or as a consequence of):    Secular of the contribute of t	Lange F	Physician		Immediate Cause (Final	one cause on eac	I/A - S	DLMIA	21017	Jer.			Onset and Death
Due to (or as a consequence of):    Cause (Disease or injury transmitted events of the part of the par		/Medical			a. Due to (o	r as a consequence of):	Jul				_	
February   1   1   1   1   1   1   1   1   1		Examiner		Sequentially list conditions	b	Valuts "	molell	is				
Section   Sect		ed sit	ine	if any, leading to immediate cause. Enter Underlying	Due to (o	r as a consequence of):						
Section   Sect	_	xecut and Il-tran	xan	that initiated events resulting in death) Last	c. Due to (o	type yeur	i					
FEMALE: 23b. Was decedent pregnant in the past 12 months?   1   Live birth 2   Fetal death 4   1   Petal death 9   Unknown   23c. If yes, outcome of pregnancy in the past 12 months? 1   Live birth 2   Fetal death 4   Petal death 9   Unknown   25   No 9   Unknown   24a. Was an autopsy finding prior to complete on death 9   Unknown   24a. Was an autopsy finding prior to complete on death 9   Unknown   25b. Was case referred to medical examination and/or investigation   25c. Place of Death (Check only one)   25c. Was case referred to medical examiner of Death (Check only one)   25c. Was case referred to medical examiner of Death (Check only one)   25c. Was case referred to medical examiner of Death (Check only one)   25c. Was case referred to medical examiner of Death (Check only one)   25c. Was case referred to medical examiner of Death (Check only one)   25c. Was case referred to medical examiner of Death (Check only one)   25c. Was case referred to medical examiner of Death (Check only one)   25c. Was case referred to medical examiner of Death (Check only one)   25c. Was case referred to medical examiner of Death (Check only one)   25c. Was case referred to medical examiner of Death (Check only one)   25c. Was case referred to medical examiner of Death (Check only one)   25c. Was case referred to medical examiner of Death (Check only one)   25c. Was case referred to medical examiner of Death (Check only one)   25c. Was case referred to medical examiner of Death (Check only one)   25c. Was case referred to medical examiner of Death (Check only one)   25c. Was case referred to medical examiner of Death (Check only one)   25c. Was case referred to medical examiner of Death (Check only one)   25c. Was case referred to medical examiner of Death (Check only one)   25c. Was case referred to medical examiner of Death (Check only one)   25c. Was case referred to medical examiner of Death (Check only one)   25c. Was case referred to medical examiner of Death (Check only one)   25c. Was case referred to medical examiner	9	sician buria	alE			ood mayer	ud vi	took	con			
The state of the s	89	ifficate g phy as the	edic		u			1				
1   Yes   2   No   3   Probably   4    24a. Was an autopsy finding prior to completion of death?  25. Was case referred to medical examiner?  25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Manner of Death   1   Yes   2   No    28a. Date of Injury   28b. Time of Injury   28c. Injury at Work?   1   Yes   2   No    27. Manner of Death   28a. Date of Injury   28b. Time of Injury   28c. Injury at Work?   1   Yes   2   No    28b. Location (Street and Number or Rural Route Number or Rural Rou	O. Box	0 0 0	ysician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No	1 ☐ Live bir 4 ☐ Pregna	rth 2 ☐ Fetal death 3 ☐ ant at time of death 5 ☐	Ectopic pregnanc Other (specify)	у				•
30. Name and address of person who completed cause of death (Item 23a) (Type. Print)	٦.	that the plant t		Part If. Other significant conditions	contributing to dea	th but not resulting in the u	nderlying cause give	en in Part I.	23e. Did	tobacco use cor	ntribute to t	the cause of death?
30. Name and address of person who completed cause of death (Item 23a) (Type. Print)	g .	quires in sign		Costiac	ac	Imma_			_ 1□	Yes 2 No	3∏ Pro	bably 4 ☐ Unknown
30. Name and address of person who completed cause of death (Item 23a) (Type. Print)	ပ္တ	aw re	olete				,				Were auto	opsy findings available
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30. Name and address of person who completed cause of death (Item 23a) (Type. Print)	<u> </u>	nysic his ce I direc	- 1		Hospital: 1   Inj	patient 2 ER/Outpatier	it 3 □ DOA Oth	er: 4 🗆 Nursin	g Home 5 Res	idence 6 🗆 Ot	her (Speci	fy)
30. Name and address of person who completed cause of death (Item 23a) (Type. Print)	ב ב	ing P	:uo	1 Natural 5 ☐ Pending	(Month,		Worl		28d. Describe	how injury occu	rred	
30. Name and address of person who completed cause of death (Item 23a) (Type. Print)	Sign	frend leath. tor: / the fi	cati	Z 🗆 Accident	0	file and the second		Yes 2 □No	206 1	(0)		
30. Name and address of person who completed cause of death (Item 23a) (Type. Print)		after of Direct Direct of In by	ertif		building	g, etc. <i>(Specify)</i>	еет, тастогу, опісе		City or To	(Street and Num wn, State)	ber or Run	al Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type. Print)		spita hours neral y filled		29a. Certifier 1 Certifying P	hysician: To the b	est of my knowledge, deat	occurred at the ti	me, date and p	lace, and due to the	e cause(s) and r	nanner as	stated.
30. Name and address of person who completed cause of death (Item 23a) (Type. Print)	:	ne Ho in 24 I he Fu ipletel	edic	(Check only 2 Medical Exa			vestigation, in my c	ppinion, death o	occurred at the time	, date and place	, and due t	to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type. Print)		Vith Com	Σ		1. 1.	0	29c. Licens	e number		29d. Date sign	ed (Month,	Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				From Cell	van M	υ	1004	1823		10/	19/1	D
		3				of death (Item 23a) (Type, 2.2 3 Www	Print)	St	TIKto.	117	219	21
State 31. Date filed (Month, Day, Year) / 32. Registrar's Signature		Sta	te				( ) Prices		- 11-181	1 NIG	/	1

DHMH 17 Rev 1/2001

State

Registrar

OCT 2 n 2010

			State of Maryland				and M	ental Hy	giene	2010	34387
			Registrar  1. Decedent's Name (First, Middle, Last)	Cer	tificate of E	<i>Jeath</i>		2. Date of Dea	Reg. No.	- 0 : 0	
	Physicia Medic		Paul Sol Harab					Month Octobe		2010 2010	3. Time of Death 10:45 p M
	Examir		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location o		000000		ounty of Deat	
20 1			8100 Connecticut Avenue #509			vy Ch			M	ontgom	ery
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last	t birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours		8. Date of Birtl <i>Month, Day</i> 04/08/		9. Birt Co	hplace (State or Foreign Intry) Romania
		V.	579-05-9476 89 Usual Residence of Decedent					04/06/	1921		Komania
	yland f sho ed at	ctor		Town or Loc							10d. Inside City Limits
	r 28a notifi	Dire	Maryland   Montgomery   Chevy	y Chas	10f. Zip Code						1 🖾 Yes 2 🗌 No
	with th	<b>Funeral Director</b>	8100 Connecticut Avenue #509			0815			10g. Citize	en of What Co US	*
	leath items er mu	Fun	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. W	Vas Decedent of His Yes, specify Cubar		gin? (Speci	fy Yes or No-	14	Race - Amer	
36	after c	l by	1 Never Married 2 Married 1 Yes 2 No		Yes 2 X No		, Риепо ні	can, etc.)	Sc	Black, White pecify:	a, etc. White
9	nours latura ical E	Completed by	3 ☑ Widowed 4 ☐ Divorced If Yes, GIVE Year or Dates.		ent's Usual Occupa						
215	in 72   e. nan "r Med	dmo	(Specify only highest grade completed)  Elementary/Seconday (0-12) College (1-4 or 5+)	(Give k	ind of work done do NOT use retired)		of working	7	TOD. KING	l of Business I	ndustry
21	ygien ygien her th	(D)	5+	Acc	countant				Ac	counti	ng
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	0	17. Father's Name (First, Middle, Last) Morris Harab		İ		,	First, Middle, I upnick	Maiden Sui	mame)	
ary	nd Me			19b Mailin	n Address (Street a				City or To	wn State Zin	Code) 20815
Σ̈́	id 2 st salth a n 27 is er trau		Jeffrey W. Harab, son	4600	North Pa	rk Av	re, Si	uite 10	)1, C	hevy Cl	nase, MD
ore	of He If iten		20a. Method of Disposition  1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  20b. Place cerr.	ce of Dispos	sition (Name of atory or other place	9)	Da	te	20c. Loca	ation - City or	Town, State
Baltimore,	t. Pag tment rtant; rjury o		4 Donation 5 Other (Specify)	onál ( ew Cer	atory or other place Capitol netery	1		/2010			ights, MD
Bal	Depar Impor any in		21. Signature of Funeral Service Licensee  MO1255	Ec. 1(	Name and Addres Iward Sag 191 Rockv	s of Facility el Fu ille	nera Pike	l Direc	tion ville	, Inc.	land 20852
			23a. Part 1. Inter the disease, or complications that caused the death. I shock, or heart failure. List only one cause on each line.					Approximate Interval Between			
	Physician/ Medical	W. Y	Immediate Cause (Final disease or condition resulting in death)  Aortic Stendard a. Aortic Stendard Aortic Ste		(Severe)						Onset and Death 2 years
1	Examiner		Due to (or as a consequen	ice of):							
		iner	Sequentially list conditions, if any, leading to immediate cause Enter Institution	nce of):							
	ransit und	Examiner	Cause (Disease or linjury that initiated events c.							1	
_	Hospital or Attending Physician. The law requires that the death certificate be executed burst after death.  Fur hours after death.  Furtheral Director: After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical E	resulting in death) Last Due to (or as a consequen	ice of):							
260	icate t phys s the t	ledic	d								
(687	ath certifica attending p for use as f	N/a	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal deceded.	y looth 2 🗆	Estania programa				230	d. Date of deli	very
Вох	death he atte ed for	Physician/Me	in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown  1 ☐ Ves Drift 2 ☐ Fetal or 4 ☐ Pregnant at time of dea	ith 5	Other (specify)	/	_			Month	Day Year
P.O.	es that the designed by the s		Part II. Other significant conditions contributing to death but not resulti	ing in the ur	derlvina cause give	en in Part I.		23e Did tol	Dacco Lise	contribute to	the cause of death?
S, F	ires the signer of the control of th	Completed by	Hyperlipidemia								obably 4 🗆 Unknown
ord	w require s been s s should	olete 	Diabetes					24a. Was a	n 2	24b. Were auto	opsy findings available
Rec	The law cate has page 2 t	E O						autops perfori	med?	prior to co death? 1 \sum Yes	ompletion of cause of
ta	sician; The certificate l irector, page	8	25. Was case referred to medical examiner?			ce of Death	n (Check or		22 110	1 2 100	22.40
Į Vi	Physicia this cerral direct	욘	1 ☐ Yes 2 ဩ No Hospital: 1 ☐ Inpatient 2 ☐ ER 27. Manner of Death 28a. Date of injury 28	R/Outpatient Bb. Time of		4 □ Nur		5X Reside			(y)
o uo	ading of the structure of tuner	cate	1  Natural 5 □ Pending (Month, Day, Year) 2 □ Accident Investigation	injury	28c. Injury work? M 1 🔲 Y	aτ ∕es 2□N		d. Describe ho	w injury oc	ccurred	
Division of Vital Records,	r Attencer deathrector: Attencer deathrector	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home building, etc. (Specify)	, farm, stree	et, factory, office		28	f. Location (St	reet and N	umber or Rura	al Route Number,
ă	urs aft ral Dii lled in	<u>a</u>		- Alexander			1	City or Town	,		
	To the Hospital or within 24 hours aft. To the Funeral Dir completed filled in	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination an	nd/or investic	ation, in my opinion	. death occ	curred at the	e time, date an	d place an	d due to the ca	suse(s) and manner stated
	To the I	≥	only one) 3 Certifying Nurse Practions To the best of my kn 29b. Signature and title of certifier	iowiedge, de	29c. License	number	-		9d. Date s	igned (Month,	
	10				125	92	29			3/10	
		Ī	30. Name and address person who completed cause of death (Item 23	a) (Type, Pri	int)	2 117	750 (	7h c C	the e	M - 1	land 20015
7	Stat		Dr. Martin Saul Kanovsky, 5530 Will 31. Date filed (Month, Day, Year)  22. Registrar's Signature	rscons	sin Avenu	e, #/	JU, (	onevy C	nase	, Mary	Land 20815
31	Registra	-	OCT 1 5 2010 Jennia B.	park	1						

			For State Registrar	State o	f Marylar		artmen <i>tificate</i>			and M	lental Hyલ્	giene Reg. No. 2	010	31.398
ı	Physicia		1. Decedent's Name (First, Middle, Anne L.		1				-		2. Date of Dea	ıth	Year	3. Time of Death 1:05р м
	Medic Examir		4a. Facility Name (if not institution, Morningside	give street and num	ber)				Location of				nty of Death	
	Funeral Director				7. Age (In yrs 83		If Under Months		If Under 2 Hours		8. Date of Birtl	<u> </u>	9. Birth	place (State or Foreign
			Usual Residence of Decedent								7/16/	1927		
	Marylan 18a-f sh tified a	Director	NY Dutch	iese		ty, Town or Loc Beacon								10d. Inside City Limits 1   Yes 2 □ No
	with the sa or 2 or 2 or 2	Funeral Di	10e. Street and Number 112 Washingt	on Aven	ue		10f. Zip	Code 125	08			10g. Citizen o	of What Cou	ntry?
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one	ed by Fun	11. Marital Status  1 ☐ Never Married 2 H Marri 3 ☐ Widowed 4 ☐ Divorced	12. Was Deced Armed For 1  Yes If Yes, Give Year or Da	ces? 2 🖾 No	H		ify Cubar	, Mexican,		cify Yes or No- Rican, etc.)		Race - Americ Black, White, sify: W	
Baltimore, Maryland 21215-0036	/ithin 72 hou iene. r than "natu the Medica	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12)  College (1-4 or 5+)  Clerk  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Clerk  16b. Kind of Business Ind  Clerk  Police D										dustry Department	
land 2	l be filed w lental Hyg rked othe tic event,	To Be	17. Father's Name (First, Middle, La Thomas Lou	ıghran						r's Name len	(First, Middle, I Bouc		ıme)	
, Mary	d 2 should alth and M n 27 is ma er traumar		19a. Informant's Name/Relationshi Kenneth M.Hal	p (Type, Print) 1/Husba	nd	19b. Mailin	g Address Wash	(Street ar	nd Number ton	or Rural Avei	Route Number, nue Be	City or Town	, State, Zip ( New	ork 12508
imore,	Page 1 annent of Hermant: If item		20a. Method of Disposition  1   Burial 2 □ Cremation  4 □ Donation 5 □ Other (Sp	3 🗷 Removal from the cify)	State St	Place of Dispos cernetery, crem • Joac	sition (Nam natory or ot	e of her place S CE	m. 1	0/15	ate 5/2010	20c. Locatio		own, State ew York
Balti	permit. Departn Importa any inji		21. Signatur of neral Service Li			2 <u>2</u> 9	№ <b>Т</b> 13Т 241	P <sup>dd</sup> P	REN	ALD a B	FUNE	RAL S lver	ERVIC Sprir	E,P.A. g,Md20910
	23a. Part 1. Enter the Assease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart allure. List only one cause on each line.  Physician/  Physician/  Alzheimer's Dementia													Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death)	Due to (c	r as a consequ	uence of):								
	red nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	b. Stetu (c	ır də d sənəsqi	uetiče otj.			_					
0	icate be executed g physician and is the burial-transit	edical Exa	that initiated events resulting in death) Last	C. Due to (c	r as a consequ	uence of):								
09/89	certificate nding phys use as the		IF FEMALE:	d	ama of progra									
Š	death	by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		inth 2 🗌 Feta ant at time of o	aldeath 3 🗌	Ectopic p Other (spe						Date of delive Month	ery Day Year
, O	The law requires that the ate has been signed by the page 2 should be detach	l by Pi	Part II. Other significant condition	s contributing to de	ath but not res	sulting in the ur	nderlying c	ause give	en in Part I.					e cause of death?
Vital Records,	aw requi	Completed									24a. Was a	n 24t	o. Were auto	psy findings available mpletion of cause of
Ä Z	in; The la ificate h or, page		25. Was case referred to medical					26 Plac	ce of Death	(Chack	1 \(\sum \) Yes	med?	death? 1  Yes	·
VIE	hysicie his cert al direct	To Be	examiner? 1 ☐ Yes 2 🛂 No	The second secon	npatient 2 🗆		3 🗆 DO	Other		`	ne 5 🗆 Reside	ence 6 🖰 O	ther (Specify	assisted
on 0	ath. r: After t	Certificate:	27. Manner of Death  1	1 '	f injury , <i>Day, Year)</i>	28b. Time of injury	M 28	c. Injury a work? 1 🔲 Y	at ′es 2□N		8d. Describe ho	w injury occu	ırred	living
DIVISION OF	al or Atte s after de il Directo id in by th		3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	28e. Place o	of Injury - At ho g, etc. (Specify	me, farm, stre	et, factory,	office		2	8f. Location (St. City or Town		ber or Rural	Route Number,
	To the Hospital or Attending Physician; The law within 24 hours after death.  To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s	Medical	(Check 2 L Medical Ex	Physician: To the be aminer: On the basis kirse Practioner: To	of examination	n and/or investi	gation, in m	ıy opinion	, death occ	urred at t	he time, date an	d place, and c	due to the cau	ise(s) and manner stated.
	vithi To the		29b. Signature and title of certifier					License r		47		9d. Date sign		
		Ì	30. Name and address of person w	ompleted cause		23a) (Type, Pr Cedar		e #	103	Col	Lumbia	.Md	21044	
	Stat Registra	e r	31. Date filed (Month, Day Year)		gistrar's Signat		Ked.					, •		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 12:30P M October 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Winter Growth Assisted Living Columbia Howard 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral**  Birthplace (State or Foreign Country) reb 20, 1910 1 □ M 2 🔀 F Months Days Hours Min **Director** 298-18-9933 Yrs 100 Ohio Usual Residence of Decedent 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Howard Columbia 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? with 23a Funeral 5247 West Running Brook Road Apt101 21044 United States items ? permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items any inJury or other traumatic event, the Medical Examiner m. 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify Specify Completed 3 ☑ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Secretary Construction Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Gustav Merkle Lavina Hammermeister 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy R. Schwartzberg/daughter 5247 West Running Brook Rd, Apt 101 Columbia, MD21044 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 10/19/2010 Woodbine, Maryland ure of Funeral Service Lice 22. Name and Address Going Home Beverly L. Cremation Service P.O. Box 784 Heckrotte, P.A. Clarksville, M ° M00957 Clarksville, MD 21029 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause or each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of SDISEASE the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and thed for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death Month Day Year 9 Unknown 9 Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? in 24 hours after death. in 24 hours after death. the Funeral Director. After this certificate ימיאיוי in by the funeral director, ps 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital Other: 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence On Other (Specify, Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

egistrar's Signature

Grecia

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 34390 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10/10/2010 Mark Damon Haggerty 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 1 XXM 2 🗆 F Months Days Hours 263-45-1587 51 14774471938 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director MD Anne Arundel Annapolis 1XXYes 2 ☐ No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral **23**a 701 Glenwood Street 21401 USA items ? hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. MX Never Married 2 Married "natural", or þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed 3 Widowed 4 Divorced the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) than Elementary/Seconday (0-12) College (1-4 or 5+) I Hygiene. Sales Retail Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If Item 27 is marked oth any liury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Richard Leroy Haggerty Carol O'Neil 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Steinmeier 5401 Foxhound Lane Baker, F1 32531 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 🙀 Cremation 3 D Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 10/13/2010 Glen Burnie, MD Signalus of Funeral Service Licenses 22. Name and Address of Facility Hardesty Funeral Home, P.A. Annapolis, MD 21401 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Renal Dialysis Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Seizure Disorder Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Traumatic Brain Injury 31yrs use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably Y Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed? this certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1xxYes 2 🗆 No Other: 2 4 Nursing Home 5 Residence 6 Other (Specify) 1XXInpatient 2 ER/Outpatient 3 DOA s after death.

I Director: After the din by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred ☐ Natural 5 Pending work? 1 ☐ Yes XX No Pedestrian vs Car Accident Investigation 6 Could not be /20/1979 unknown <sup>M</sup> 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined To the Hospital of within 24 hours a To the Funeral D Street Annapolis, MD Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

\*\*Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signatyle and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar Lu

OCT 15 2010

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

park

William P. Jones, MD 6131 Shady Side RD. Shady Side, MD 20764

32. Registrar's Signature

D06054

10/15/2010

			For State	State of Maryla				/lental Hyg	ilene	0 01001
		_	Registrar  1. Decedent's Name (First, Middle, Las	t) .	Ce	rtificate of De	eath		leg. No L U	0 34391
ACTUAL TO SERVICE ACTUAL TO SE	Physicia Media		Max F. H	amis				2. Date of Deat Month	-	3. Time of Death
)	Examir	ner	4a Eacility Name (if not institution, give	street and number) Hal Cente		4b. City, Town, or Lo	ocation of Death	2/	49: County of	Death
P	Funeral Director		Social Security Number 6.1Se		. last birthday) Yrs.		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 4,		9. Birthplace (State or Foreign Country)
			Usual Residence of Decedent					Dury 4,	1929	MD
21215-0036 within 72 hours after death with the Maryland	a-fsh fied at	Director	10a. State 10b. County		City, Town or Lo					10d. Inside City Limits
the Ma	or 28: e notii		MD Carroll 10e. Street and Number		stmins	10f. Zip Code	<del></del>	1 1	0g. Citizen of Wh	1 ☐ Yes 2 💢 No
with	is 23a nust b	Funeral	1741 Peppermint L	ane		21157			U.S.	*
r death	r item iner n		11. Marital Status 1 ☐ Never Married 2 ※ Married	12. Was Decedent Ever in U Armed Forces?		Was Decedent of Hispa f Yes, specify Cuban, I	anic Origin? (Spe Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race -	American Indian, White, etc.
036 rs afte	ral", o Exam	ed by	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates.		1 ☐ Yes 2 🛣 No 🤱	Specify:		Specify:	White
5-0	"natu edical	Completed	15. Decedent's Ed (Specify only highest gra		16a. Dece	dent's Usual Occupation	on ina most of worki	na I	16b. Kind of Busin	
121 rithin 7	giene. ner than t, the Me	Som	Elementary/Seconday (0-12)	College (1-4 or 5+)	lite. D	O NOT use retired)  C Electric:		'g	מח הים	lorz
land 2	al Hyg d othe vent,	æ	17. Father's Name (First, Middle, Last)		masce			e (First, Middle, M	H.P. Fo	Ley
yar Id be	and 2 should lealth and M em 27 is mai her traumat	욘	Max Harris			Jo	osephine	Szewczy	/k	
Mar 2 shou			19a. Informant's Name/Relationship (Ty	be, Print)	1	ng Address (Street and				
<b>re</b> ,			Lois Harris/wife  20a. Method of Disposition	20b.	Place of Dispo	Peppermint sition (Name of			Ster, MD 20c. Location - Ci	
imo Page	ment c ant: If ury or		1 Surial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			v Memorial	į			
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after	Department of F Important: If ite any injury or ot once.		21. Signature of Funeral Service License		22	. Name and Address of	of Facility <b>Pri</b>	tts Fune	eral Home	& Chapel, PA
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,								
	ysician/	9 N	Interval Between Onset and Death  Interval Between Onset and Death  Chronic Obstructive Pulmonary Disease  Due to (or as a consequence of):							
	Medical caminer									
	c	ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseq	quence of):	rardia	X IN	Sorch	cn	24 hours
suted	nd ransit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	D				**:		
e exec	physician and s the burial-transit		resulting in death) Last	Due to (or as a conseq	quence of):					
7 <b>60</b> icate b	physics the k	ledical		d						
x 68	attending r I for use as	an/N		3c. If yes, outcome of pregna	ancy	Cotonia prognanau			23d. Date o	f delivery
<b>Records, P.O. Box 68760</b> The law requires that the death certificate be executed	the att hed for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of 9 Unknown	Fetal death 3				Month	Day Year
P.O. I	been signed by the should be detached	by Ph								te to the cause of death?
dS, I			6						3 2 No 3	☐ Probably 4 ☐ Unknown
aw rec	as be	Completed						24a. Was an autopsy	24b. Were	e autopsy findings available r to completion of cause of
T F	certificate has birector, page 2 sl		05 Wes					perform 1 🗆 Yes 2	ed? deat	
/Ita	after death.  Director: After this in by the funeral d	To Be	25. Was case referred to medical examiner?  1   Yes   2   No   Hospital:							
of Phy			27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury accurred							pecify)
tendir		Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be		M 1 ☐ Yes 2 ☐ No					
DIVISION Of VITAI RECORDS, tal or Attending Physician: The law requires after death			4 Homicide determined				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
- Hospita 4 hour		edical	29a. Certifier (Check (							
o the l	omple	Σ  .	only one) 3 Certifying Nurse 29b. Signature and title of certifier	Practioner: To the best of m	y knowledge, de	eath occurred at the tim	e, date and place	, and due to the ca	ause(s) and manne	r as stated.
_	NJL		Jodale-B. N	Zendusty		D 51		296	d. Date signed (M	
V	15		30. Name and address of person who co	and address of person who completed cause of death (Item 23a) (Type, Print)  Maryland 21157						
	State	:	UDAY 13 NAN B1. Date filed (Month, Day, Year)	32. Registrar's Signa			n Height	s Medica	al Center	r, Westminster
	State Registra	-	OCT 18 2		A. 1	bare				
					1 11					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Grace Estalyn Hendry 1445 Medical October 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Heron Point Chestertown Kent Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth g. Birthplace (State or Foreign 1 □ M 2 □XF Days Hours Min. Colorado Director 562-30-3754 89 Usual Residence of Decedent 28a-f show 10a, State 10b. County 72 hours after death with the Maryland Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 No MD Kent Chestertown 0 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 449 Heron Point items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. and Mental Hygiene. 1 Never Married 2 Married Completed by 2 X No Yes Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Divorced Specify: White traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Teacher Education permit. Page 1 and 2 should be filed wi Department of Health and Mental Hygic Important: If item 27 is marked other any injury or other traumatic event, ti once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ Theodore John Kreps Esther Elvira Corsberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Hendry-Husband 449 Heron Point Chestertown, MD 21620 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 D Burial 2 X Cremation 3 D Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation 10-15-2010 Chester, Maryland 21. Signature of Funeral Service Licensee <sup>22</sup> Name and Address of Facility ellows, Helfenbein & Newnam Funeral 30 Speer Road Chestertown, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ HROVIC UBSTRUCTIVE PULMONARY disease or condition >10 years Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and the attending physician and hed for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Pregnant at time of death Month Year detached 9 Unknown Anter mis certificate has been signed by a funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ADVANCED DEMENTIA 1 ☐ Yes 2 ☐ No 3 🇖 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 1 ☐ Yes 2 🗙 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital: 1 Tes Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D004158 8 30, Name and address State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 120 Marie Karen Howell 10 20 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Western Mar unterland 41(00) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) MD 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth Min (MSnth, Day 16, 1965 **Director** 215-90-4948 45 Usual Residence of Decedent 28a-f show 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene.
item 27 is marked other than "natural", or items 23a or 28a-f shov 10a. State 10b. County notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Allegany Cumberland 1 Xes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 123 Penn Avenue 21502 USA 11 Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates 3 Divorced Completed white traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) disabled N/A To Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles E. Howell, Jr. Marjorie H. (Wallen) Howell 19a. Informant's Name/Relationship (Type, Print)
Charlie Howell Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 655 Park view Avenue Cumberland MD 21502 Father other 1 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite any injury or otl 20c. Location - City or Town, State Date 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State St. Mary's Cemetery 10/23/2010 4 ☐ Donation 5 ☐ Other (Specify) Cumberland MD 22. Name and Address of Full Full Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. shock, her the disease, or complications that caused heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, of heart fail. Immediate Cause (Final Onset and Death Physician/ disease condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) and Il-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been siç page 2 should b Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director; After this certificate Permpleted filled in by the funeral director, page performed? Yes 2, No 25. Was case referred to medical B 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 Ø No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Man of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural injury 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medica 29a. Certifier 1 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 7 6660 4 29b. Signature a Willowbrook Rd, Cumberland, MD 21502 address of person who completed cause of death (Item 23a) (Type, Print) 12500 31. Date filed (Month, Day, 32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34394 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Goldie Johnson October Day 2010 11:25P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 40 Boxwood Rd. Annapolis Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🏋 F Hours Jan 1ay <sup>(ear</sup> 1913 Director 212-42-0975 97 Maryland Usual Residence of Decedent 28a-f shov should be filed within 72 hours after death with the Maryland and Mental Hygiene.
is marked other than "natural", or items 23a or 28a-f shoraumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland Anne Arundel Annapolis 1 Tes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 40 Boxwood Rd. 21403 USA 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. \$ 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3X Widowed 4 □ Divorced Completed Specify: Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 10th 0 Homemaker None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ဂ္ Shadrack Davis injury or other traumatic Adella Kess 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Geraldine J. Smith(Daughtek) 40 Boxwood Rd. Annapolis, Md. 21403 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Hill Date 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10-14-10 Brooklyn, Md. 21. Signature of Funeral Service Licensee Miniame Redeseof RecilitSons Mortuary, 821 West St. Annapolis, Md. 21401 100483 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, Myocardia disease or condition Medical resulting in death) Due to or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner es e pubblication of the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events physician and the burial-trans Due to (or as a consequence of) resulting in death) Last signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) Pregnant at time of death Dav Year 1 ☐ Yes 2 ₹ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۾ 23e. Did tobacco use contribute to the cause of death? Completed 1 Yes 2 No 3 Probably 4 D Unknown Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy perform death? 1 Ves 2 No 1 Yes 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident Investigation 1 🗌 Yes 2 🗌 No 3 Sulcide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 10-15-10 017737 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ritchie Hwy, GB 31. Date filed (Month, Day, 1 5 2010 State egistrar's Signature racke

DHMH 17 Rev 7/2009

Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death LARCHARET Physician/ 7.20 P NOENHOL 2010 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Burtonsville Sanctuary at Holy Cross If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Country) Maryland 1 M 2 X F 827. Par/9920 Director 220-10-9279 90 Usual Residence of Decedent r 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 No Laurel Prince George's Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a on any injury or other traumatic event, the Medical Examiner must be a Funeral U.S.A. 20707 15122 Laurel Oak Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian. 11 Marital Status Armed Forces?
1 ☐ Yes 2 🕱 No Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 ☐ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Government Elementary/Seconday (0-12) College (1-4 or 5+) Printing Office Clerk/Homemaker 6 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Ella Mae O'Neill Karl Muller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3765 Thunder Hill Dr., Prince Frederick, MD 20678 Adam Johnson, Jr. - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cem. 10/19/2010 Silver Spring, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hines-Rinaudi Funeral Home, Inc. . Signature of Funeral Service Licensee 11800 New Hampshire Ave., Silver Spring, MD 20904 OFO omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, shock, or heart failure. Interval Between Onset and Death Immediate Cause (Final CEREPRENASCULAR Physician disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): D To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending household. ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 U Q Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ONGESTIVE 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? performed? Yes P No 1 ☐ Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatura and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8 mi pleted cause of death (Item 23a) (Type, Print) ALTO MI) 21249 TASNEEM 31. Date filed (Month, Day, Year) Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment of F		l Mental Hy	/giene	34396	
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- Andrews	Examir	ner	4a. Facility Name (If not institution, give 6148 Maryland Hi 5. Social Security Number 6. Se	ghway	e (In yrs. last birthday)	4b. City, Town, or Deer If Under 1 Year	Park		4c. County of I	Death rrett	
Baitimore, Maryland 21215-0036	Funeral Director	Director		TM 2127 F	84 Yrs.	Months Days	Hours Mi	n. (Month, D	0 1926	Birthplace (State or Foreign Country) PA	
	the Marylan 28a-f show		10a. State         10b. County           MD         Garret           10e. Street and Number	t	10c. City, Town or Lo	rk				10d. Inside City Limits 1 □Yes 2 ☎No	
	s 23a or		6148 Maryland Hi			10f. Zip Code 215			10g. Citizen of Wha		
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, if a Medical Examinar must be recitived at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	lo	Was Decedent of H If Yes, specify Cuba 1 □Yes 2 🙀 No	lispanic Origin? an, Mexican, Pue Specify:	(Specify Yes or Norto Rican, etc.)	14. Race - A Black, V Specify:	American Indian, Vhite, etc. White	
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	vuld be filed Mental Hyg arked other atic event, I	To Be C	17. Father's Name (First, Middle, Last)  John Nycek			nousewire	18. Mother's Na	ame (First, Middle	Own Ho o, Maiden Surname) ovel	ome	
	1 and 2 sho Health and em 27 Is me		19a. Informant's Name/Relationship (Ty Sharon Hazelwood- 20a. Method of Disposition			East Oak			per, City or Town, Sta 21550 20c. Location - City		
	permit. Pages Department of Important: If ite any injury or o		1 ■ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Ligense		Garrett N	natory or other plac Memorial	Gardens	23/10	0akland		
ñ	Deg Imp		21 N. 2nd St, Oakland, MD 21550  23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between.								
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	e Hospital 24 hours e Funeral letely filled	Medical Co	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	vithin To the comp	Me	29b. Signature and title of certifier	) Kai	200	29c. License			29d. Date signed (M	1	
		8	30. Name and address of person who com	npleted cause of dea	ath (Item 23a) (Type, F		650	2 00	Blend 1	-2010 d 21550	
L	Stat Registra	te	31. Date filed (Month, Day, Year)  OCT 2 5 2010	32 Aegistrar	's Signature	de la	NY VIVE	1 ou	mara, N	10,21330	

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Physicia Medi		Arlene June Krichbau	n 				:		_	Year	4:05 p M
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nd <b>how</b>	] _	Usual Residence of Decedent  10a. State 10b. County	10c. C	City, Town or Loc	cation					1	0d. Inside City Limits
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Mary should and Me is mar		19a. Informant's Name/Relationship (Type, F		19b. Mailin	g Address (Street a	nd Number	or Rural I	Route Number	City or Town, Sta	te, Zip C	ode)
473 € 2		Henry B. Krichbaum/Husba		28	300 Urbana 1	Drive,	Silve	er Spring	, MD 20906	)	
Kaltimore, Department of Hea Important: If item any injury or other		1	oval from State		ation (Name of atory or other place <b>morial Pari</b>		ct. 1	te 18, 010	20c. Location - C		
Baltimo permit, Page Department of Important: If any injury or		21. Signatury Funeral Service Licensee	2.	222 F1	Name and Address	offins	Funer	al Home	Inc.		
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Physician/		23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one call immediate Cause (Final				, 545/1 45 64	ardiao or r	oopiratory arre			Approximate Interval Between Onset and Death
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al or A		4 ☐ Homicide determined	le. Place of Injury - At he building, etc. (Specif)	ome, farm, stree	t, factory, office		281	f. Location (Str City or Town,	eet and Number o State)	r Rural F	Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1	n the basis of examinatio	n and/or investic	ration in my oninion	death occur	rred at the	a time date and	place and due to	the seus	a(a) and mannay stated
To the within To the complete t		only one) 3 Certifying Nurse Pra  29b. Signature and title of certifier	tioner: To the best of m	y knowledge, de	ath occurred at the t 29c. License n	ime, date an	id place, a	and due to the	cause(s) and manne od. Date signed (N	r as stat	ed.
3		Rabert H Luce	W MD		D555	522			ctober 13,		
	;	30. Name and address of person who comple Robert H. Gerard, MD	ted cause of death (Item 1500 Forest			orine *	MD 30	910			
State	9	31. Date filed (Month, Day, Year) OCT 15 2010				ъгнид,	DID ZU	∍TO			
Registra		301 10 2010	Dewes fo	2. 19000							

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34398 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death October 13, 2010 4:45A. M 4b. City, Town, or Location of Death 4c. County of Death Bethesda Montgomery

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

1 ∐ Yes 2 ⊈Mo

29d. Date signed (Month, Day, Year)

10/13/10

Year

1 ☐ Yes 2 No

Washington, DC

1. Decedent's Name (First, Middle, Last) Physician Elizabeth Ann Knight /Medical 4a. Facility Name (If not institution, give street and number) Examiner Manor Care 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 30, 1945 7. Age (In yrs. last birthday) Funeral 1 □ M 2 🔀 F Months Days Hours 579-58-7131 65 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show Maryland Prince George's Director Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7504 Burgess Lane 20744 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or Specify: Black 1 □Yes 2 No þ If Yes, Give Year or Dates Specify: 3 ☐ Widowed 4 🏋 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. Registered Nurse Medical is marked other 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Jason Washington Josephine Braxton ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 is other tra Gerald B. Knight -son 3320 Jones Bridge Road Chevy Chase, MD 20815 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State National Harmony Mem. Park 10/20/2010 Landover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** PHOMA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 □ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one 1 Yes 2 No Certification: To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 1 ☐ Yes 2 ☐ No

5 Pending investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier,

State Registrar

3

Medical

31. Date filed (Month, Day, Year) OCT 15



29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrar 34399 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2010 Year **Physician** Month October 17, Juliana Kowal 2:25 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Emmitsburg St. Vincent Care Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💢 F 94 Yrs 214-54-6124 Maryland Director Apr 25, 1916 Usual Residence of Decedent 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at Emmitsburg 1X Yes 2 □ No Director Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 21727 335 South Seton Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates: Specify: \$ Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 72 th and Mental Hygiene. 7 is marked other than "na Religious Community College (1-4or 5+) Elementary/Secondary (0-12) Daughters of Charity Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ladyslowa Potocka Frank Kowal ೭ 19a. Informant's Name/Relationship (Type. Print) Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any Injury or other traun once. 333 South Seton Ave, Emmitsburg, MD 21727 Cora Anne Signaigo, Servant 20b. Place of Disposition (Name of Streemeters Scapillary or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 10/20/2010 Emmitsburg, MD 4 Donation 5 Dother (Specify) Provincial House 21. Signature of Funeral Service Licens 22. Name and Address of Facility Myers-Durboraw Funeral Home 210 W Main St, Emmitsburg, MD 21727  $\lambda a \nu$ 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Elvas Tag disease or condition resulting in death) 10hulap /Medical Due to (or as a cons uence of): Examiner 20x Mary an Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a conseq ence of): The law requires that the death certificate be executed Ouse physician and s the burial-trans Solul that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 ☐ Other (specify) P.0. been signed by the should be detached 1 Yes 2 Main 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2  $\alpha$ 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has page 2 autopsy perforn Vital 1 ☐ Yes 2 ☐ No 1 □Yes 2/No After this certification, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🐼 Ño Other: Division of Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 ☐ Accident 5 Pending n 24 hours after death.

ne Funeral Director: Af
pletely filled in by the fur 1 ☐ Yes 2 □ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hor To the Fune completely fi (Check only one) the 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

WIL

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

euftl

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of N	laryland / Dep <i>Ce</i>	artment of rtificate of		nd Mental I	Hygiene	010	34400
	Observio		1. Decedent's Name (First, Middle, La	st)				2. Date of	Death	V	3. Time of Death
	Physic /Medi		Chun Woo Kim					Octob	er 14,	$20\overset{\mathrm{Year}}{0}$	1:20 P M
	Exami		4a. Facility Name (If not institution, give		·	4b. City, Town,	or Location of	Death	4c. Co	ounty of Death	
4			Montgomery Villag			Montgom				Montgon	
	Funeral Director		5. Social Security Number 6. S	iex 7.7 MZM 2□F	Age (In yrs. last birthday, 71 Yrs.	If Under 1 Year Months Days	If Under 2	4 Hrs. 8. Date of (Month,	Birth Day, Year)	9. Birth	place <i>(State or Foreign</i> ptry) n Korea
			Usual Residence of Decedent		/1			July	17, 193	3 3000	ii kulea
	irylan show	_	10a. State 10b. County		10c. City, Town or Lo	ocation					10d. Inside City Limits
	ath with the Marylan 23a or 28a-f show ust be notified at	Director	Maryland Montgome	ry	Montgomer		e				1 □Yes 2 No
	with th	Ë	10e. Street and Number			10f. Zip Code				n of What Cou	,
	sath v	era	19301 Watkins Mil	⊥ Road     ₁2. Was Deceder	t Everia II S 40	20886				ed Stat	
21215-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Evaimt. ust te notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 反 Divorced	Armed Forces  1  Yes 2   If Yes, Give Year or Dates	No	was Decedent of If Yes, specify Cub 1 ☐ Yes 2 🛣 No		in? (Specify Yes or Puerto Rican, etc.)		. Race - Ameri Black, White, pecify:	
2-0	72 hours 'natural'', dical Eva	Completed	15. Decedent's Ed	lucation	16a. Dece	dent's Usual Occu	pation		16b. Kind	of Business/In	
21	- 200	ldr.	(Specify only highest gra	College (1-4o		kind of work done DO NOT use retire	during most ( ed)	of working			
121	hed w hygier her th	ပ်	-	4	Teac	her				cation	
Maryland	l be fill intal H ed ot	Be	17. Father's Name (First, Middle, Last)  Doo Ho Kim				ľ	s Name <i>(First, Mid</i> ye Nam	dle, Maiden Su	rname)	
Ž	should bd Me mark matic	2	19a. Informant's Name/Relationship (	Time Print)	19h Maili	on Address (Street		or Rural Route Nu	mhas City as T	C4-4- 7:	- 0-1-1
Ma	nd 2 salth ar 27 is rrtrau	33	Sunny Hyun Kim (S		4343	Lee High	way, #	204, Arli	ngton,	اVirgin کا Virgin	ia 22207
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than amy injury or other traumatic event, In M. Once.		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specif		Hegrop	esition (Name of matory or other pla DLICAN	сө) Ос	ctober		tion - City or To	
alti	oortar injur		21. Signature of Funeral Service Licer		Crem	atory 2. Name and Addre		2010 DeVol Fu	Alexa	ndria,	Virginia
m	permi Depa Impo any ii		May 1 to	M				Drive, Ga		-	D 20877
			23a. Party. Into the disease, or compared to the disease,	olications IIII cause	ed the death. Do not en	er the mode of dyi	ng, such as c	ardiac or respirator	y arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		Parkinson'	s Diseas	e				Onset and Death
in the	/Medical Examiner		resulting in death)	Due to (or a	s a consequence of):						
	LAGIIIIICI	'n	Sequentially list conditions, if any, leading to immediate	D	ension						
6	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events		s a consequence on: :es Mellitus						
D	ficate be executed physician and s the buriat-transit	Exal	that initiated events resulting in death) Last	C	s a consequence of):	•					
8760,	te be ysicia e bur	dical		.d.							
	ntifica ng ph as th	Medi	IE EEMALE.								
P.O. Box	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No 9 □ Unknown		2 Fetal death 3 at time of death 5	] Ectopic pregnand ] Other <i>(specify)</i> _	<b>Ру</b>		230	I. Date of deliv Month	ery Day Year
Records, P	quires that n signed b	Completed by PI	Part II. Other significant conditions of	ontributing to death	but not resulting in the u	nderlying cause giv	en in Part I.				he cause of death?
တ္တ	aw requir s been si should b	olete						24a. W	as an 2	4b. Were auto	psy findings available
m.	The law ate has age 2 s	E O						pe	rformed?	death?	psy findings available mpletion of cause of
Vital	sician: The certificate h rector, page	Be C	25. Was case referred to medical examiner?				26. Place o	f Death (Check onl	y one)	1 ☐ Yes	2 □No
of V	S 0 =		1 Yes 2 XNo	Hospital: 1	ient 2 🗆 ER/Outpatier	t 3 □ DOA Oth	er: 4 🔀 Nurs	ing Home 5 ☐ Re	esidence 6	Other (Special	(y)
		on:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of Inj (Month, D	iury 28b. Time of Injury	Wor	ry at k?	28d. Describ	e how injury or		
isio	Attending ir death. ector: After by the fune	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	00 Bi (1			Yes 2 □ No				
Division	l or A after d Direc	Certification: To	4 ☐ Homicide determined	28e. Place of Ir building, e	jury - At home, farm, str tc. <i>(Specify)</i>	eet, factory, office		28f. Location City or 7	(Street and N Town, State)	lumber or Rura	I Route Number,
	To the Hospital or Attene within 24 hours after death To the Funeral Director: completely filled in by the	Medical Co	29a. Certifier 1 Certifying Ph	ysician: To the besiner: On the basis and manners	t of my knowledge, death of examination and/or in	n occurred at the ti vestigation, in my	me, date and opinion, death	place, and due to to occurred at the time	he cause(s) an	d manner as s	stated. o the cause(s)
	Fo the within 2 Fo the comple	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date s	igned (Month,	Day, Year)
			1 Hing Ga	otimo		D411	62			er 15,	
			30. Name and address of person who o	ompleted cause of	death (Item 23a) (Type,	Print)	torm	VID 2087/			
	Sta	te	21 Date filed (Month Day Veer)		1.6:		I	200/4 كلت			
	Registra	ar	OCT 18 201	O Bertun	J. ga	Part .					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death O 2. Date of Death Physician/ Month October 19, 2010 Eileen Mary Lashbaugh 1514M Medical 4a, Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Western Maryland Regional Medical Center Cumberland Allegany 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) August 11, 1925 9. Birthplace (State or Foreign Funeral Days 1 M 2 X Hours Country) Maryland 213-22-3271 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Allegany Lonaconing 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17204 Jackson Run Road 21539 USA death v 12 Was Decedent Ever in LLS 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give permit. Page 1 and 2 should be filed within 72 hours after 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", Completed White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) l Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+ Outreach Worker Senior Citizens Center 0 other traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked or ည Alexander Scott Mary Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. Sherry Hadley 51 Douglas Avenue, Lonaconing, Maryland, 21539 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date October 22 1 Burial 2 Cremation 3 Removal from State Moscow Mills, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Mt. View Cemetery 2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A 8 East Main Street Lonaconing, MD 21539 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on ach line Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ng physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 by the attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ò in the past 12 months? Pregnant at time of death Month Day Year 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Chronic obstructive Pulmonary Disease 1. Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Congetive Heart Failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.
2 hours after death.
2 Funeral Director. After this certificate has Lieted filled in by the funeral director, page 2 s autopsy performed? Yes 2 No eritoritis 2 🗌 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: ျှ 1 Tes 1 FInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Tes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier

State Registrar Douglas Ave. Lonaconing, Md 21539

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

)evlin

homas

31. Date filed (Month, Day, Year)

# Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed

			Pieas					<b>K. Ensure A</b> Health and N	-	`	gibie.	
		For State		State 0	i iviai yiai i		tificate of L			711	10	34402
		Registrar  1. Decedent's Name (Fi	irst, Middle, L	.ast)			tinoato oi E	Journ	2. Date of Death	g. No.		3. Time of Death
Physicia Medic		Wilkey E	. Lowe						October	15 2	.0 Year	6:30p M
Examin		4a. Facility Name (if not			ber)		4b. City, Town, or	Location of Death		4c. Count	y of Death	
		313A Willi					Forest			Harf		
Funeral Director		5. Social Security Numb		. Sex 1 □ <b>X</b> M 2 □ F	7. Age (In yrs. la	ast birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day) Dec 30	Year) 924	g. Birthpi Count	lace (State or Foreign ry) VA
		Usual Residence of Dec				0.5			Dec. 30	,1924		VA
f sho	햦	10a. State 10l	b. County		10c. City	y, Town or Lo	cation				10	Od. Inside City Limits
r 28a- notifie	Director	MD 10e. Street and Number	Harfo	rd		Forest						1 Yes 2 X No
23a o	ral	313A Will		Circle			10f. Zip Code 21050		10	Og. Citizen of USA	What Count	ry?
ems sems	Funeral	11. Marital Status	IIICII	12. Was Dece	dent Ever in U.S		Vas Decedent of H	ispanic Origin? (Spe	ecify Yes or No-		ce - America	an Indian,
or it	þ	1 Never Married	2 XMarrie	Armed For 1 AYes If Yes, Give	ces? 2  No		f Yes, specify Cuba □ Yes 2 <b>X</b> No	n, Mexican, Puerto	Rican, etc.)		ack, White, e	
tural" al Exa	Completed	3 Widowed 4 C		Year or Da						Specify	Whi	te
n "na Aedic	힐	(Specify		grade completed)		(Give I	lent's Usual Occup kind of work done ( O NOT use retired)	ation during most of worki	ing	6b. Kind of E	Jusiness Ind	ustry
yiene. giene. er tha the N		Elementary/Seconda	ay (0-12)	College (1-	4 or 5+)	1	Finisher			Automo	bile	
al Hyg d oth		17. Father's Name (First	t, Middle, Las	t)					e (First, Middle, Ma	aiden Surnam	ne)	
Ment Ment narke	욘	George Lov						Sophia	Brown			
h and 7 is not traum		19a. Informant's Name/		. ,,,			-	and Number or Rura Circle F		-		
Healt Healt tem 2		Laverna Lo		TIE	20b. P		sition (Name of	•		20c. Location		
pernil.: Fage I and 2 should be littled within 7.2 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 X Burial 2 □ C 4 □ Donation 5 □	Cremation 3	Removal from	State C	emetery, cren	natory or other plac	⊛ 10/2 Memoria1	1/2010	ear, D	•	TI, Otalo
partm portal y inju		21. Signature of Funera			Der			d Funeral				
B B E G		1	/~			2	59 E. Ma	in St. El	kton, MD	21921		
		23a. Part 1. Enterne d shock, or eart fai	disease, or o	mplications that c	aused the death	h. Do not ente	er the mode of dyin	g, such as cardiac o	or respiratory arres	t,		Approximate Interval Between
hysician/		Immediate Cause (Fina disease or condition	al	_a_ <i>N</i>	letas	tatic	color	n ca	ncer			Onset and Death
Medical Examiner		resulting in death)	•	Due to (	or as a consequ	ence of):						
	Jer	Secuentially list conciti if any, leading to immed	diate 🖊	b. Due to (	or as a consequ	ence of):					_	
anslt	Examiner	cause. Enter Underlying Cause (Disease or iinjuithat initiated events	lg liry	C								
ian ar ırial-tr	cal Ex	resulting in death) Last		Due to (	or as a consequ	ence of):						
physic the bi				d								
nding Ise as	_	IF FEMALE: 23b. Was decedent preg	onant I	23c. If yes, outo						23d D:	ate of delive	n/
atter d for u	icia	in the past 12 mon	ths?	4 🗌 Pregr	Birth 2		Ectopic pregnand Other (specify)	;y				Day Year
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igned be de		Part II. Other significan		contributing to de		ulting in the u		en in Part I.				e cause of death? ably 4 Wunknown
bould	Completed	Drack		001	,	7300	, C		11			
has b	du	7/04/	4/6	can	-				24a. Was an autopsy perform	· I	prior to con death?	sy findings available apletion of cause of
ificate or, pa		25. Was case referred to	o medical	can	er_		26 Pl	ace of Death (Check	1 Yes 2	No	1 Yes 2	2 🗍 No
is cert direct	To Be	examiner? 1 - Yes 2 - Yes	0	Hospital:	Inpatient 2	ER/Outpatien	Oth	er.	me 5 Residen	ice 6 🗆 Oth	ner (Specify)	
fter th		27. Manner of Death  1 Natural 5	Pending	28a. Date of	of injury h, Day, Year)	28b. Time of injury	28c. Injun work	/ at :	28d. Describe how			
tor: A the fu	Certificate:	2 Accident	Investigat	ho				Yes 2 No				
after of Direction by	Cerl	4 Homicide	determine	28e. Place	of Injury - At ho ig, etc. (Specify,		eet, factory, office		28f. Location (Stre City or Town,		er or Rural F	?oute Number,
within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	ical	29a. Certifier 1	Certifying Pl	nysician: To the be	est of my knowl	edge, death o	ccured at the time	, date and place, an	d due to the cause	e(s) and manr	ner as statec	
iin 24 <b>he Fu</b> iplete	Medical							on, death occurred at e time, date and plac				se(s) and manner stated. ted.
To the com	_ [	29b. Signature and title	of certifier	VA	2		29c. License	number 2 9 2 2	29	d. Date signe	d (Month, D	ay, Year)
		> Molen	1 1.	100			1230	3933		0 //	7/20	710
TIVA		30. Name and address of Robert S 31. Date filed (Month, Da	of person wh	o completed cause	of death (Item	23a) (Type, P	L Road	Siste in	Bel	Air	Maul	and Zinis
Stat	e	31. Date filed (Month, Da	ay, Year)	32. Re	egistrar's Signat	ure		-0.61 - 10	- 1-01	111/	/1	THE PROPERTY OF
Registra	ır	OCT	1920	10 Sent	u B.	par						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October Shirley Jean Link 2010 5:57 p <sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 704 Bayly Road Cambridge Dorchester 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Sept. 17, 1940 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** 1 🗆 M 2 🖾 F Months Days Hours 216-38-8556 Director 70 Maryland Usual Residence of Decedent f show th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Dorchester Cambridge 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 704 Bayly Road 21613 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. δ 1 Never Married 2 Married ☐ Yes 2 🗓 No Maryland 21215-0036 1 ☐ Yes 2 K No Specify: If Yes, Give white Specify. Completed 3 Widowed 4 Noivorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) waitress restaurant 1 and 2 should be filed w of Health and Mental Hygi item 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Alexander Dyott Ida Mae Scott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Sard sister 23586 Grove Road, Preston, MD permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Springhill Cemetery 10/14/10 Easton, MD 21. Signature Apruneral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ atherosclerotic coronary vascular disease disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner hyperlipidemia unknown Sequentially list conditions, Examine If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of, or Attending Physician; The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 2 X No 9 Unknown 1 ☐ Yes ∠ 2 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director. After this certificate has completed filled in by the funeral director, page 2 s autopsy performed? Yes 2 X No death? 1 🗌 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Hospital Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 X Yes 2 🗌 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work 1 Yes 2 🗌 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital 6 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 🗋 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated xamener 9 pleted cause of death (Item 23a) (Type, Print) Towne Centre Blad Annapolis 31. Date filed (Month, Day, Year) State Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Mildred Lyons 5:30pm<sup>M</sup> /Medical 10/14/2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Althea Woodland Silver Spring Montgomery If Under 24 Hrs. 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year 08/24/31 **Funeral** 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Months Hours 1**X** M 2 □ F 79 Yrs. Director Florida 578-42-4670 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits item 27 is marked other then "natural", or items 23a or 28a-f show other traumatic event, the Medical Exant an inustice notified at Md Montgomery Silver Spring Director 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1000 Daleview 20901 USA Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Be Completed by Specify: 3 ☐ Widowed 4 MDivorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "ns any injury or other traumatic even." (Specify only highest grade completed) Elementary/Secondary (0-12) Coilege (1-4or 5+) Asst Director Labor Department 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Cephus Williamson Mildred McGhee ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen A. Herbert Daughter 6878 Riverdale Road #713 Lanham, Md 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 10/18/10 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) Riverdale Crematory RiverDale, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Snead Mortuary Service, P.A. 1409 Fairlakes Pl Suite B Bowie Md 20721 23a. Part1. Enter the disease, or complications, h. t caused the death. shock, or heart failure. List only one cau, h. n. ea.n. line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ZONEUVS neimer disease or condition resulting in death) /Medical (or as a consequence of). Examiner Sequentially list conditions, if any leading to make a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospitel or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physiclan/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) detached Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: 2X No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 🗙 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident Injury 5 Pending death. 1 □ Yes 2 □ No investigation Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified 30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) Fito and Ave MITE 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Marylan State of Marylan 21 per fh,gg	nd / Depa <b>909 , L1 / (</b> Cer	artment of h 01/2010al tificate of L	Health and N Beath	Mental Hygid	ene g. No. 2010	34405
	Physici: Medi		Decedent's Name (First, Middle, Last)  Ruby LaMarca				2. Date of Death	Pay 2010	3. Time of Death
	Exami		4a. Facility Name (if not institution, give street and number) Williamsport Retirement Vi	11		Location of Death	0000	4c. County of Deat	h
~~	Funeral	7	5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday)	If Under 1 Year	amsport	8. Date of Birth	Washing	gton thplace (State or Foreign
	Director		236-24-5025	Yrs.	Months Days	Hours Min.	Nov. 20	,1916 Co	TN
	/land f show d at	ţo		ity, Town or Loca	ation				10d. Inside City Limits
	r 28a-i notifie	Director	WV Berkeley Ma	rtinsk					XXYes 2 ☐ No
	with th	Funeral			10f. Zip Code 254 (	01	10	g. Citizen of What Co USA	untry?
36	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	1 Never Married 2 Married 1 Yes 2 No If Yes, Give	lf.	as Decedent of Hi	spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Wh	e, etc.
2-0	2 hours "natur dical B	plete	15. Decedent's Education (Specify only highest grade completed)	16a. Decede	ent's Usual Occupa	ation	16	6b. Kind of Business I	
121	ithin 72 ene. • than '	Completed	Elementary/Seconday (0-12)  1 2  College (1-4 or 5+)  3	life. DO	NOT use retired)	uring most of worki	ng		,
nd 2	filed w al Hygi d other vent, t	Be	17. Father's Name (First, Middle, Last)	bea	uticiar 		e (First, Middle, Mai	cosmeto den Surname)	ology
<u>yla</u>	uld be d Menta marked natic e	ပ	Jordan Dolivar Bean					na Groom	
, Ma	nd 2 sho lealth and m 27 is r		19a. Informant's Name/Relationship (Type, Print) Ron Garcia/son in law	19b. Mailing 4 3 4 8	Address (Street a	nd Number or Rura Cliff R	l Route Number, Ci	ty or Town, State, Zip	Code) ID 20636
Baltimore, Maryland 21215-0036	permit. Page 1 a Department of H Important: If ite any injury or ott		1XXBurial 2 Cremation 3 Removal from State	Place of Disposi cemetery, crema sedale	ition (Name of atory or other place • Cemete	9) !		c. Location - City or Martinsb	
Balt	permit. Departr Import. any inji		21. Signature of Funeral Service Licensee  Joseph R. Spewock per dvr	22.1	Name and Addres	s of Facility RC	sedale	Funeral	
7	nysician/ Medical	i v	23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence)	Isch	the mode of dying	such as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death OML WERK
	Examiner	<u>-</u>	Seguentially list conditions. b.	1007	tensio	M			
	ted d Insit	Examiner	If any, leading to immediate Due to (or as a consequence). Enter Underlying Cause (Disease or injury	uence of):					
	cernificate be executed nding physician and use as the burial-transit	el Exa	that initiated events c.  Due to (or as a consequence of the content of the conte	uence of):					
09/	cate be physic the bu	edical	d						
Š	death certifi ne attending ed for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 │ Yes 2 │ No 9 │ Unknown  IF FEMALE: 23c. If yes, outcome of pregnant 1 │ Live Birth 2 │ Feta 4 │ Pregnant at time of d 9 │ Unknown	ıl death 3 🔲 🛭	Ectopic pregnancy Other (specify)			23d. Date of deliv	very Day Year
л О	s tnat t gned by be deta	þ	Part II. Other significant conditions contributing to death but not resu	ulting in the und	derlying cause give	n in Part I.	23e. Did tobac	co use contribute to t	the cause of death?
rds	require Deen si hould I	eted	Dementia,				1 🗌 Yes	2 No 3 □ Pro	obably 4 🗆 Unknown
Vital Records,	within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	Completed					24a. Was an autopsy performed	prior to co	opsy findings available ompletion of cause of
<u>. Ta</u>	s certifi irector	To Be	25. Was case referred to medical examiner? 1  Yes 2  Hospital:		Other	ce of Death (Check			
0	ter this		27. Manner of Death 28a. Date of injury	28b. Time of injury	28c. Injury a	4 Nursing Hon	ne 5  Residence 8d. Describe how in	e 6 Other (Specifinity occurred	y)
lon	death.	Certificate:	2 Accident Investigation			es 2 🗆 No			
Division	rs after al Direct ed in by		4 Homicide determined 28e. Place of Injury - At hor building, etc. (Specify)		, factory, office	2	8f. Location (Street City or Town, St	and Number or Rura ate)	l Route Number,
- incom	in 24 hour	Medical	29a. Certifier (Check only one)  Check only one)  Certifying Physician: To the best of my knowle and the desired from the des						
F.	with Com		29b. Signature and title or certifier		29c. License r			Date signed (Month,	
		-	30. Name and address of person who compreted cause of death (Item)	MD 230) (The T :		00632	33	10/17	12010
ف	H-/		Shabid Mahmood 580 A		27n AV	R Hall	n weter	10 21	742_
	State Registra	_	31. Date filed (Month Carry 2) 2010 32. Jegistrar's Signatu	I. Sa	de	3			

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Barbara Josephine McKenzie October 19 2010 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Frostburg Village Nursing Home Frostburg Allegany 7. Age (In yrs. last birthday) 5. Social Security Number 214–48–3393 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Days Sept. Day Ye Hours <sup>ar</sup>1947 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ms 23a or 28a-f sho must be notified at death with the Maryland Director Allegany Frostburg 10f. Zip Code 21532 10e. Street and Number 10g. Citizen of What Country? 81 East Mechanic St. Apt. 113 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2★★No n "natural", or item ledical Examiner n Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 X Never Married 2 Married and 2 should be filed within 72 hours after u Health and Mental Hygiene. tem 27 is marked other than "natural", or ☐ Yes f Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2XXNo Specify: 3 🗌 Widowed 4 🗌 Divorced Year or Dates ed other than "natu event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) ulth and Mental Hygiene. 27 is marked other than r traumatic event, the Mo life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) convalescent care 12 care giver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Lovanna Allen ည Joseph R. McKenzie 19a. Informant's Name/Relationship (Type, Print) Cathy Broadwater/ sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10701 Huffman Hollow Road, Frostburg Maryland 21532 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 10/2<sup>Date</sup> 20c. Location - City or Town, State 1 Kurial 2 Cremation 3 Removal from State St. Marys Cemetery Lonaconing Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home Way 111 Church St. Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Carcinoma Medical resulting in death) Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 Month been signed by the should be detached g Unknow Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by assentine Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Hypertreduis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 Yes 2 No Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 70 မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical

3. Time of Death

10:50 P M

10d. Inside City Limits

terval Between Onset and Death

Year

29d. Date signed (Month, Day, Year)

XX Yes 2 No

State Registrar 29a. Certifier (Check

31. Date filed (Month

29b. Signature and title of certific

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Jesus Tan, 4 Broadway, Frostburg, MD

OCT 21 2010

DHMH 17 Rev 7/2009

istrar's Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

021244

3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Cassandra Iris McLaurin Month / C/TUbe 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Doctors Community Hospital Lanham Prince Georges Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 253-84-8684 Days Hours Min. June 19, 1948 62 South Carolina Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Prince Georges Fort Washington 1 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2905 Blooming Court 20744 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. African 1 XNever Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Divorced American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) Howard University College (1-4 or 5+) 5+ Physician Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Fred McLaurin Vivian Ruth McCollum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Portia T. Edwards/Sister Box 3541 Albany, Georgia 31706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/18/2010 | Suitland, MD Cedar Hill Cemetery Signature of Funeral Service Licensee 22. Name and Address of Facility McGuire Funeral Service, Inc. Elliberre anna K 7400 Georgia Ave., N.W. Wash., D.C. 20012 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death disease or condition resulting in death) nat Due to (or as a consequence of)

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permit. Page Department o Important: If

Examiner must be notified

72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician d be detached for use as the burial peen this certificate has page 2 funeral director, After

Division of Vital Records, P.O. Box 68760

Completed by Physician/Medical

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Certificate:

Medical

Se_u.ent(clly list nonational in any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a consequent of the consequent of	to pema.		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1  Live Birth 2 Fetal d 4  Pregnant at time of dea 9  Unknown	eath 3  Ectopic pregnancy	23d. Date of deliv	very Day Year
Part II. <b>Other significant conditions</b>	contributing to death but not resulti	ng in the underlying cause given in Part I.	autopsy prior to co	obably 4 Inknown opsy findings available ompletion of cause of
25. Was case referred to medical		26. Place of Death (C		2 No
examiner? 1  Yes 2 No	Hospital:	- Other:		
27. Manner of Death			Home 5 Residence 6 Other (Specify	)
1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	b. I ime of injury at work?  M   28c. Injury at work?  1   Yes 2   No	28d. Describe how injury occurred	
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined		, farm, street, factory, office	28f. Location (Street and Number or Rural City or Town, State)	l Route Number,
Check 2   Medical Exam	niner: On the basis of examination an	Q/Or investigation in my opinion death occurre	, and due to the cause(s) and manner as state ad at the time, date and place, and due to the ca place, and due to the cause(s) and manner as st	una(a) and mannau stated
29b. Signature and title of certifier		20a License sumber	20 1 5 1 1 1 1 1 1 1 1 1 1	

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State

Registrar

within 24 hours after deat To the Funeral Director: apleted filled in by the

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Malcolm Martin October 8 10:20 AM 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 8501 Old Seven Locks Road Bethesda Montgomery Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign 213-38-8214 89 Months Days Hours Min (Month, Day, Year) 2/10/1920 Austria Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Montgomery Bethesda 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8501 Old Seven Locks Road 20817 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? 1 ☐ Yes 2 🔀 No 1 Never Married 2 X Married Black, White, etc. If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u> Physician / Professor</u> Medical / Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Razel Glaubach Kalman Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arline Martin - wife 8501 Old Seven Locks Road Bethesda, MD 20817 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 $fenck{X}$ Burial 2 $\Box$ Cremation 3 $\Box$ Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Garden of Remembrance 10/10/10 Clarksburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Danzansky-Goldberg, Memorial Chapels Inc II/O Rockville Pike Rockville MD 20852 M01163 23a. Eart : Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Due to (or as a consequence of): disease or condition resulting in death) Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or linjury that initiated events 10 resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760 signed by the been sign certificate has the lirector, page 2 s After this filled in by the funeral within 24 hours

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Medical

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Funeral

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Baltimore, Maryland 21215-0036

Permit. Page 1 and 2 should be filed within 72 hours after dee Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any injury or other traumatic event, the Medical Examiner once.

Physician/

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Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnance 1  Live Birth 2 Fet 4  Pregnant at time of 9 Unknown	al death 3 Dectop	ic pregnancy (specify)		23d. Date of delivery Month Day Year
þ	Part II. Other significant conditions of	ontributing to death but not res	sulting in the underlyir	ng cause given in Part I.		o use contribute to the cause of death?
<b>Completed</b>	25. Was case referred to medical				24a. Was an autopsy performed? 1 □ Yes 2 📈	
Be	examiner?	Hospital:		26. Place of Death (Ch		
은	1 Yes 2 □ No	1 Inpatient 2	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 X Residence	6 Other (Specify)
ıte:	27. Manner of Death  1  Natural 5  Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work?	28d. Describe how inju	ary occurred
fice	2. Accident Investigation	Sep 23 2009	0800M	1 ☐ Yes 2 ☐ No	Pedestria	n strick by mv.
al Certificate:	4  Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	<u>+</u>		13e/609da	nd Number or Rural Roup Number e) Condy La Thomas n mo 20517
edical	29a. Certifier 1 Certifying Physical Check 2 Medical Exami	sician: To the best of my know iner: On the basis of examination	ledge, death occured n and/or investigation, i	at the time, date and place, in my opinion, death occurred	and due to the cause(s) a	and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

D00428

29d. Date signed (Month, Day, Year)

2010

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State Registrar

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31. Date filed (Month, Day, Year) OCT 15

nature and title of certiff

32 Registrar's Signature

ma Om 6

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ira Brecher MD 2101 Medical Park Drive Silver Spring MD 20902

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of	Marylan		artment of He <i>tificate of De</i>			giene Reg. No. 0	0 34409
			Decedent's Name (First, Middle	e, Last)					2. Date of Dea	ith	3. Time of Death
	Physicia Medio		Barbara	Miriam Mi	lls				Octobe:		Year 10 2101 <sup>M</sup>
,	Examin	er	4a. Facility Name (if not institution		•		4b. City, Town, or Lo			4c. County o	
- A	Funeral		Shady Grove A  5. Social Security Number		Spital Age (In yrs. la		Rockvi	11e If Under 24 Hrs.	8, Date of Birth		9. Birthplace (State or Foreign
	Director		213-42-8817	1 □ M 2 🕱 F	85	Yrs.		Hours Min.	Nov 30	1924	Country) England
	d now nt	L	Usual Residence of Decedent  10a. State 10b. County		10c City	y, Town or Lo	cation				10d. Inside City Limits
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	or 28	Dir	10e. Street and Number	sex			Lewes 10f. Zip Code			10g. Citizen of Wh	
	s 23a	Funeral	21677 Willow	Lane			19958	8		Englan	đ
	death item ner m		11. Marital Status	12. Was Decede Armed Force			Was Decedent of Hisp f Yes, specify Cuban,	anic Origin? (Spe Mexican, Puerto	ecify Yes or No- Rican, etc.)		- American Indian, White, etc.
38	after al", or Exami	d by	1 ☐ Never Married 2 ☐ Ma 3 🕱 Widowed 4 ☐ Divorced	If You Give				Specify:		Specify:	
Maryland 21215-0036	hours natur lical E	Completed	15. Decede	nt's Education	5.	16a. Deced	lent's Usual Occupation	on		16b. Kind of Bus	White iness Industry
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72	d with	Be C	17. Father's Name (First, Middle,	2			wner		1		Repair
and	be file ental F ked o c eve	To E		liam Saye	re		11	Viole		Maiden Surname)	
ary	hould and Ma s mar umati		19a. Informant's Name/Relations		-10	19b. Mailir	ng Address (Street and				te, Zip Code)
Σ	nd 2 sl salth a nn 27 is er tra		Janice Long Co	e/daughter			-			-	ryland 20878
ore	e 1 ar Tof He Fiter		20a. Method of Disposition 1 ☐ Burial 2 X Cremation	3 ☐ Removal from St:			sition (Name of natory or other place)		Date	20c. Location - C	city or Town, State
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other (	Specify)			ney Cremat				ne, Maryland
Bal	permi Depar Impo any ir once.		21. Signature of Funeral Service	Thomas	M00	Gc   957   Be	Name and Address on Home (everly L. H	rematio Heckrott	n Servic e. P.A.	ce P.O. 1 Clarksv	30x 784 ille, MD 21029
			23a. Part 1 Enter the disease, o shock, or heart failure. List	complications that cau only one cause on each	sed the death						Approximate Interval Between
F	Inysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a			cular c	eccide	nt		Onset and Death
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ord	v requ	lete							24a. Was a	n 24b. We	ere autopsy findings available
၁ဓင	sician: The law sicertificate has birector, page 2 s	Completed		-			_		autops perfor 1  Yes	med? de	or to completion of cause of ath?  Yes 2 \sum No
e	ysician: T iis certifica director, p		25. Was case referred to medical examiner?				T	e of Death (Check		ZAGINO	3 100 2 3 10
<u> </u>	Physic this or al dire	၉	1 Yes 2 No	Hospital: 1-2 Inp 28a. Date of i	patient 2 🗆	ER/Outpatien 28b. Time of				ence 6 Other	(Specify)
Division of Vital Records, P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Within 24 hours after death.  To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transt	Certificate:	1 Natural 5 Pendir 2 Accident Investi	ng (Month, i	Day, Year)	injury	28c. Injury at work? M 1 \square Yes	s 2 🗆 No	28d. Describe ho	ow injury occurred	
VISIO	or Atte fter de irecto n by th	ertif	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	inod 28e. Place of	Injury - At hor etc. (Specify)		et, factory, office		28f. Location (St City or Town		or Rural Route Number,
	spital o		29a. Certifier 1 Certifying	Physician: To the best	of my knowle	edge, death o	occured at the time, da	ate and place an	d due to the cau	se(s) and manner	as stated.
	he Ho in 24 h he Fur pleted	Medical	(Check 2 Medical E		of examination	and/or invest	igation, in my opinion, o	death occurred at	the time, date an	d place, and due to	the cause(s) and manner stated.
	Vith Com	— r	29b. Signature and title of certifie	10.0	n		29c. License nu			29d. Date signed (	
		ļ	flede	. Milwe	ik r	uD_	101	4294		Octob	cr 14,2010
	8		30. Name and address of person	who completed cause of	of death (Item	23a) (Type, P	Purrell M	he 6	aithers	y Mad	20179
E	Stat Registra	e	31. Date filed (Month Day Year)	9 2010 32. Megis	strar's Signati	g.	arkel				/

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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		For State		Sta	ite of I	Marylan		artment of		ind Mei	ntal Hy	giene	201	0 3	1.1.10
		Registrar  1. Decedent's Name	e (First, Middle,	Last)			Cei	rtificate of	Death		Date of Dea	Reg. N	6 0 1	0 0	4410
Physicia Medic		Emm	A	5		ME	YEI	2			Month /O	L		200	ime of Death
Examin	er	4a. Facility Name (if 1688 Alic			nd numbe	r)		4b. City, Town, Annapol		Death		- 1	c. County of I		
Funeral		5. Social Security N		6. Sex	7.	Age (In yrs. I	ast birthday)	If Under 1 Yea	r If Under 2		Date of Birt	th	9	. Birthplace (S	State or Foreign
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Na Louis Mey		p (Type, Prin	t)			ng Address (Stree						e, Zip Code)	
f Healt f Healt item 2 other		20a. Method of Disp				20b. F		osition (Name of	Jule A	Date				ty or Town, St	ate
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Physician/		shock, or heal Immediate Cause ( disease or conditio	(Final	nly one cause	on each	line.	-	)emes						Onse	al Between t and Death
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Medic	in the past 12 r 1 ☐ Yes 2 ☑ 9 ☐ Unknown	No	4 🗆		it at time of d		Other (specify)				1	Month	Day	Year
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equires een sig ould b			_							-	1 🗆	Yes 2	2 □ No 3	Probably	4- Unknown
has bo	Completed									- 1	24a. Was autor perfo			r to completion	dings available on of cause of
in: The ifficate or, pag	Be Co	25. Was case referre	ed to medical				<u></u>	26	Place of Death	(Check on	1 Yes	2		Yes 2 N	10
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ling Ph After th funeral	ate:	27. Manner of Death 1 Natural	h 5 🗌 Pending	1	Date of i	njury Day, Yea <i>r)</i>	28b. Time o injury	wo	ury at ork?	28d			iry occurred		
Attencr death	Certificate:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	Investiga 6  Could n determin	ot be				M 1 L reet, factory, office	」Yes 2 ∐ N		. Location (S	Street a	nd Number o	or Rural Route	Number,
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To the Hospital or Attending Physician: The law requires that the dewithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached.	Medical	(Check 2		t <b>aminer:</b> On t	the basis o	of examination	n and/ <i>o</i> r inves	occured at the ting stigation, in my oping death occurred at	ni <i>o</i> n, death <i>o</i> cc	curred at the	time, date a	and plac	e, and due to	the cause(s) a	and manner stated
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep	eartment of Health and I		201	0 31.1.11
			Registrar  1. Decedent's Name (First, Middle, Last)	runcate or Death	2. Date of Dea	Reg. No. U	3. Time of Death
	Physicia Medic		Angela Jeanne Menter	-		16 <sup>Pay</sup> 2010	
	Examin	er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	)	4c. County of	of Death
			Montgomery General Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Olney If Under 1 Year   If Under 24 Hrs.	T		pomery
	Funeral Director		5. Social Security Number 6. Sex 1 7. Age (In yrs. last birthday) 1 ☐ M 2 ☒ F 80 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birtl (Month, Day Jan. 19,	Year	Birthplace (State or Foreign Country)  DC
			Usual Residence of Decedent		Jan. 19,	1930	
	and shov	ō	10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	Mary 28a-f	rec	MD Montgomery S	Silver Spring			1 ☐ Yes 2 🗗 No
	a or 2		10e. Street and Number	10f. Zip Code		10g. Citizen of W	hat Country?
	ıs 23 Just	Funeral Director	3300 Niles Street	20906		USA	
	death item ner n		11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-		- American Indian,
36	after I", or xami	l b	1 Never Married 2 Married 1 Yes 2 K No	1 ☐ Yes 2 ☒ No Specify:	,	Specify:	
3	atura cal E	etec	Total of Dates.	edent's Usual Occupation			White
5	n 72 h an "n Medi	Completed by	(Specify only highest grade completed) (Give	e kind of work done during most of work DO NOT use retired)	king	16b. Kind of Bus	siness Industry
212	withir giene er tha the		Elementary/Seconday (0-12) College (1-4 or 5+)	maker		Own Hon	me
g	be filed within 72 hours after death with the Maryland endel Hygiene watel Hygiene do cher than "natural", or items 23a or 28a-f sho cevent, the Medical Examiner must be notified at	Be (	17. Father's Name (First, Middle, Last) Fired Redmond	18. Mother's Nan	ne (First, Middle, I	Maiden Surname)	
<u>X</u>	ould be filed within 72 hours after death with the Maryland Montal Hygene.  marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at.	입	ried Nearon	Helen			
altimore, Maryland 21215-0036	2 sh thar 17 is trau		l .	ing Address (Street and Number or Rui Box 113, Dickerson, M		City or Town, Sta	ate, Zip Code)
စ်	je 1 and 3 t of Healt If item 2 or other		20a. Method of Disposition 20b. Place of Disp			20c. Location - 0	City or Town, State
ē	0		1 X Burial 2 Cremation 3 Removal from State cemetery, cre	matory or other place) Ct	• 20, 010		oring, Maryland
<b>=</b>	permit. Page Department Important: I any injury or						
				2. Name and Address of Facility Francis J Collins Fun 00 University Blvd. W			20901
			23a. Part 1 Shiter the disease, or complications that called the death. Do not en shock, or heart failure. List only one cause on each line.		~		Approximate Interval Between
÷F	Пузісіані		Immediate Cause (Final disease or condition	ier of	Pav	Crea	Onset and Death
-	Medical Examiner		resulting in death)  Due to (or as a consequence of):				
		Jer	Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence of):				
	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events  c.				
	exect an an rial-tra	Ě	resulting in death) Last  Due to (or as a consequence of):				
09	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	dical	d				
687	rtifica ing p e as t	/Me	IF FEMALE:				
Вох	ath ce	ian	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 Live Birth 2 Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date Mon	e of delivery th Day Year
ŏ.	ne des rthe a	Physician/Me	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 g ☐ Unknown	☐ Other (specify)			or bay roa
O.	that the	by Pł	Part II. Other significant conditions contributing to death but not resulting in the		23e. Did to	bacco use contrib	bute to the cause of death?
S,	n sign	ed b	Acute renal Fa	11000	1 🗆 ነ	′es 2□No 3	3 ☐ Probably 4 ☐ Unknown
Š	w req	Completed			24a. Was a	n 24b. W	Vere autopsy findings available rior to completion of cause of
Še	sician: The law is certificate has the law injector, page 2 s	)om		,	autop perfor 1 🗆 Yes	med? de	eath?
Ö	stan:	Be (	25. Was case referred to medical examiner?	26. Place of Death (Chec			
5	hysic his ce Il dire	은	1 Yes 2 140 Hospital:		ome 5 Resid	ence 6 D Other	(Specify)
פֿר	ling P	ate:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending  28a. Date of injury (Month, Day, Year)  28b. Time of injury injury	work?	28d. Describe he	ow injury occurred	d
201	ttend death stor; / the f	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	005		D ID I Marks
Division of Vital Records, P.O.	il or A after Direc d in by		4 Homicide determined building, etc. (Specify)	reet, factory, office	City or Tow		r or Rural Route Number,
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed ynith tay hours after death.  To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occured at the time, date and place, a	nd due to the cau	se(s) and manner	as stated.
	the H thin 24 the Fi	Me	(Check 2 Medical Examiner: On the basis of examination and/or inveonly one) 3 Certifying Nurse Practioner: To the best of myknowledge.	death occurred at the time, date and pla	ce, and due to the	cause(s) and man	nner as stated.
_			29b. Signature and title of certifier  A 7 C/ Ma Human	29c. License number		1	(Month, Day, Year)
9					99	10	17/2018
			30. Name and address of person who completed cause of death (Item 23'a) (Type, Ata Motamedi, MD 18111 Prince Philip Dr				
	Stat Registra		31. Date filed (Month, Day, Year)  32. Registrar's Signature	ales			
	negistr	٠.	UCI 18 2010 Cerus B. 19.				

	Al	MEI	Plea TD #7,8,& 9 PER	se Type or FH G909 11	Print in	Black I	ndelib	ole Ink	<b>c. Ens</b>	sure A	II Copies	s Are	Legib	ole.		
			1 - For State Registrar	Oldio 0	i iviai yiai		rtificat			una iv		Reg. No.	201	0	344	12
	5'		1. Decedent's Name (First, Middle								2. Date of Dea	ath			3. Time of I	Death
	Physicia Medic		Mary Edith Mur								Octobe	r 21	, 20Ĭ	ľÖ	1:55	₽M
	Examin	er	4a. Facility Name (if not institution,		ber)		1 1	, Town, or					County of			
and the	Funeral		6959 Dam #4 Ro 5. Social Security Number		7. Age (In yrs. I	ast birthdav)		harps er 1 Year		r 24 Hrs.	8. Date of Birt	Washington  f Birth  9. Birthplace (State or Fore				
	Director		218-30-4076	1 □ M 2 🏋 F	77	Yrs.	Months	Days	Hours	Min.	JULY <sup>th,</sup> 27	Year 1933 Country MARYLAN			ND	
	lt sow	_	Usual Residence of Decedent  10a. State 10b. County		10c Cit	y, Town or Lo	neation							140	d Institute Cite	. 5 June 74 -
	arylan a-f sh fied a	Director		ington										100	d. Inside City	
	or 28 e noti	ä	10e. Street and Number	HISCOIL		harpsl		p Code			- T	10g. Citiz	zen of Wha	at Countr		
	s 23a	Funeral	6959 Dam #4 Roa	d			2	1782				Uni	ted S	State	S	
	death item		11. Marital Status	12. Was Deced	ces?	S. 13.			spanic Or	rigin? (Spec	cify Yes or No- Rican, etc.)	$\overline{}$	4. Race -		n Indian,	
36	after al", or xami	d by	1 ☐ Never Married 2 ☐ Marr 3 【XWidowed 4 ☐ Divorced	If Yes, Give	)		1 🗆 Yes					s	Specify:			
9	hours natura ical E	Completed	15. Deceder	Year or Dat it's Education	ies.	16a. Dece	dent's Usu	iał Occupa	ation				nd of Busir			- :
215	in 72 e. han "ı e Med		Elementary/Seconday (0-12)	st grade completed)  College (1-	4 or 5+)	(Give life. D	kind of wo OO NOT us	ork done d e retired)	uring mos	st of workir	ng	, , , , , , , , , , , , , , , , , , , ,			,,	
2	d with fygien ther tl nt, the	Be	12				<u>Nur</u>	se						edic	a1	
and	oe file intal H ced of	일	17. Father's Name (First, Middle, L <b>Arnold S. Price</b>	*							(First, Middle, I <b>H. Nich</b>		,			
Z.	ould by Me		19a. Informant's Name/Relationsh			19h Maili	na Addres	s (Street a			I Route Number			e Zin Co	del	
Š	d 2 sh alth a 1 27 is er trau		Linda Mead / Da			1					, N. Sa					n
ore,	of He fitem		20a. Method of Disposition		20b. F	Place of Disponentery, crea	sition (Na	me of			er 25,		ation - Cit			
Ĕ	Page ment tant: I		1 🔀 Burial 2 □ Cremation 4 □ Donation 5 □ Other <i>(S</i>		Mt.	Olive	et Cei	meter	<b>y</b>	20		Frede	erick	, Ma	rylan	d
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service L	censee	101	, 70 K	eeney	nd Addres and	s of Facili	ford	PA Fune	eral	Home.	,		
	Physician,		23a. Part 1. Enter the disease, of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a		h. Do not ent					t Fred r respiratory arre		k, Ma	A	Approximate nterval Betwo	reen
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate this cause (Disease or iinjury	b. Due to (a	or as a consequ	uence of):										
092	icate be executed g physician and is the burial-transit	I— I	that initiated events resulting in death) Last	c	or as a consequ	uence of):										
# 7 8 ~ G Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the but	Completed by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes → No 9 ☐ Unknown		Birth 2 🗌 Feta ant at time of d	aldeath 3	Ectopic Other (s		/			23	3d. Date o Month		ay Ye	ar
ds, P.C	quires that en signed l ould be det	ted by F	Part II. Other significant conditio	ns contributing to de	ath but not res	ulting in the u	underlying	cause give	en in Part	l.	23e. Did to				cause of dea	
Fecor	The law rearte law rearte has be page 2 sho	Comple	Cancel	Myllife	ng Ty	ر در ا					24a. Was a autopoperfor	sv	prio deat	r to comp	y findings avoletion of car	ailable use of
# 12	ician: Sertific ector,	To Be	25. Was case referred to medical examiner?	Hospital:		)				ath (Check	only one)					
, Ž	Phys	. To	1  Yes 2  Xe	1 🗌 Ir 28a. Date o	npatient 2  finiury	ER/Outpatier 28b. Time of		OA Other	_ 4 L N		ne 5 Reside			Specify)		
n o	rth. : After	cate	atural 5 Pending	) (Month	n, Day, Year)	injury	м	work?	ທີ່ Yes 2.⊑	. 1	od. Describe no	ow injury o	occurred			
Divisio	ital or Atter urs after des ral Director lled in by the	al Certificate:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	28e. Place of building	of Injury - At ho g, etc. (Specify,	)				S	28f. Location (St City or Town	n, State)			oute Numbe	5
	Hospita 24 hours Funeral eted fillec	Medical	(Check 2 L Medical Ex	Physician: To the be- caminer: On the basis	s of examination	and/or inves	tigation, in	my opinior	n, death o	ccurred at t	the time, date an	nd place, a	and due to	the cause	e(s) and man	ner stated.
	To the within to To the comple	Σ	only one) 3 Certifying  29b. Signature and title of certifier	Nurse Practioner: To	ine pest of my	r knowledge, o		rred at the License		e and place			and manne signed (M			
	->=0		· (A)	1 ( 1	1	_ /	75	D16					101	22	1,1	
			30. Name and address of person w	no completed cause	of death (Item	23a) (Type, F	Print)	- 210	140						1 9	
25-			Casper E. Clin				th St	treet	, Fr	ederi	ick, Man	rylar	nd 21	701		
0	Stat Registra		31. Date filed (Month, Day, Year)	1 20 0 D	gistrar's Signat		barr	2								

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rederick Danie		1- For State Registrar		tate of Maryla		rtificate			d Mental		Reg. No	20	0 3441
Physici Medical Exami		Decedent's Nam     Freder	e (First, Midd ick Da		ett					2. Date of Month	Day	Year	3. Time of Death 1325 hrs
		4a. Facility Name (		on, give street and nu	mber)		1 "	, Town, or	Location of Dea			c. County of Dea	
Funeral		5. Social Security N	lumber	6. Sex	7. Age (In yrs. I	ast birthday)		der 1 Yea			f Birth(MN	M/DD/YYYY) 9. B	Birthplace (State or
Director		535-62-12 Usual Residence o		1 M 2 F	54	Y	rs. Mon	ths Day	s Hours N	lin. Nov	19, 19	955	ounWashington
v any			10b. County		10c. City	, Town or Loc	ation	<u>-</u>					10d. Inside City Limits
Maryland 28a-f show d at once.	tor	Maryland 10e. Street and Nu		George's	Su	iitland	1406.7	- 0 - 1 -			T40- 0		1 Yes 2 XX No
MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland tht and Mental Hygiene n 27 is marked other than "natural", or items 23a or 28a-f sho numatic event, the Medical Examiner must be notified at once	Director	4207 Offut						ip Code 20746			Tug. Ci	itizen of What Co USA	iuntry?
ath with items 23	Funeral	11. Marital Status  1 Never Marrie	ed 2 📉 M	arried Armed Fo					spanic Origin? ( n, Mexican, Puer		No-	14. Race - Ame White, etc.	erican Indian, Black,
after de al", or i	by Fu	3 Widowed		orced If Yes, Give Year	²∐ № 1987–1999	) 1	Yes :	2 <b>XX</b> No	specify:			Specify: W	<i>h</i> ite
hours a 'natura Ex mi	ed b			cify only highest grad					tion (Give kind o		16b.	Kind of Business	s/Industry
036 thin 72 ne than '	Completed	Elementary/Second	ondary (U-12)	College (1-	-4 or 5+)		Pa	ayro11	Special	ist		Hotal	
21215-0036 wid be filed within 7 Mental Hygiene marked other than c event, the Medica		17. Father's Name							18, Mother's Nar		•	n Surname)	<del></del>
212' uld be Mental marke c event	To Be	Sic 19a. Informant's Na	ney Ma			19b. Maili	ng Addres	ss (Stree	Marian et and Number o	Kit r Rural Route	_	City or Town, Sta	te, Zip Code)
Jre, MD 21215-0036 ss I and 2 should be filed within 72 hours a of Health and Mental Hygiene If item 27 is marked other than "natural her traumatic event, the Medical Ex min				Marlett - W			7 Offi			buitland,			
는 s 등 등 의		20a. Method of Disp 1 X Burial 2		n 3 Removal fro	m State	Place of Disper crematory or o	other place	e)	Oct	Date 27, 201		. Location - City o heltenham	
Baltimore, permit. Pages 1 at Department of He Important: If ite		4 Donation 5 21. Signature of Fu			Mai 1533	ryland V			metery	æ Funer			
		Hum	) ay	Y					andria Fe	erry Road	l, Cli	nton, MD 2	
Physician // /Medical		failure. List onl	y one cause	DIT.	<b>JLTIPLE</b>	INJUR	IES _			or respiratory	arrest, sh	lock, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (I or condition resulting		Due to (or as a	consequence o	Seizu:	IC I	1301	der				
	er	Sequentially list conif any, leading to im		b. Due to (or as a	consequence of	f):							
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xecuted n and - transit	ial Ex			d									
6 ਸ਼ਿਕ		W UNPENDED		AMENDED 23/	1. 28A-	, 28a-f F, PER	per ME G	me 8	2912 2- 8/14/12	l4−ll v TRT		d Data of delive	
Box 68760, e death certificate be the attending physic of for use as the bur		23b. Was decedent past 12 months		1 Live bi	utcome of pregr ith int at time of de	2 F	etal death Other (Spe		Ectopic preg	nancy	23	3d. Date of delive Month	Day Year
Box ne death the atte	hysi	1 Yes 2 N		nown 9 Unkno									
Division of Vital Records, P.(). Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn	و	Part II. Other signif	icant condit	ions contributing to	death but not re	esulting in the	underlyin	g cause g	jiven in Part I.		_		o the cause of death?  obably 4  Unknown
Records, The law require	Completed										topsy	prior to	utopsy findings available completion of cause of
ital Recician: The last certificate h	S	05.14						00.01		1 <b>✓</b> Ye	erformed?		
of Vital ng Physician After this certi nneral directo	m	25. Was case referr examiner?  1 ✓ Yes 2	ed to medica	Hospital:	patient 2	ER/Outpatier	nt 3 [		of Death (Chec Other Nurs	k only one) ing Home 5	Resid	ence 6 🗹 Othe	er; Scene
1 of Jing Ph After t	on: To	27. Manner of Death	1	28a. Date o	of Injury 10 10 10 10 10 10 10 10 10 10 10 10 10	28b. Time of 1:19			y at Work?	28d. Descri			UBJECT FELL
Division tal or Attendi rs after death. al Director: A	icati	2 X Accident	- 🖂	stigation 3-26	of Injury - At ho	unknev ome, farm, stre			ves 2 X No	28f. Locatio	n (Street	icle and Number or R	tural Route Number, City
Divi	Certification:	3 Suicide 4 Homicide		d not be mined (Specify)	ro	adway ]	HOTEL	ROO	M	or Tow	n, State)	151 AT.I.I	ENTOWN RD INGS, MD
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:	Medical	I out out only		nysician: To the best miner:On the basis of	examination ar								
To with	Me	29b. Signature and	title of certifie	and manner sta	ated.		29	c. License	e number		29d.	Date signed (Me	onth, Day, Year)
		Theodo	u /1	1. King	TR.	en . D		O.C.	M.E. or	5 agr	Oc	tober 20, 201	0
		30. Name and addre Theodore M		who completed oduse MD. Assistar	of death (Item of Medical E		111 P	enn Str	eet, Baltimo	re, MD 212	201		
St: Regist	_	31. Date filed (Monti	Day Year	1 2010 32. Reg	jetrar's Signatu	re di L	bare	V					

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1500 p M Thomas Henry Nix 10 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 96 Shingle Camp Terrace McHenry Garrett Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year 03 14 1 **№** M 2 □ F Months Days Hours Min. Director 247**-**56-2063 74 1936 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Fairfax 0akton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3409 Valewood Drive 22124 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give 1956 – 1966 Year or Dates. 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 12 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Aaron Nix Lucille Johnston permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Florence Delaney-wife 3409 Valewood Drive, Oakton, VA 22124 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State any injury or 4 Donation 5 Other (Specify) Cumberland Crematory | 10/23/2010 Cumberland, MD Signature of Funeral Service Licenses 22. Name and Address of Facilit David A. Burdock Funeral Home P.A. 21 2nd St, Oakland, MD 21550 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ terio sde ti a co 10m disease or condition resulting in death) 09 Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ng physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending properties for use as IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year signed by the a ld be detached f 1 ☐ Yes 2 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Records, 1 Yes 2 No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy e Hospital or Attending Physician: The I 124 hours after death. e Funeral Director: After this certificate heleted filled in by the funeral director, page performed? 1 Yes 2 No 25. Was case referred to medical examiner?
1 Yes 2 No Division of Vital 26. Place of Death (Check only one) Be Jammy & Other: 4 Nursing Home 5 Residence 6 Hother (Specify) ပ 1 Inpatient 2 ER/Outpatient 3 DOA Home 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 2 No Investigation Accident Suicide Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completed To the Within 2 only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 16 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
P. Daniel Miller, 69 Wolf Acres Drive, Oakland, MD 21550 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar 32 Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

**Physician** /Medica Examine **Funeral** Director To Be Completed by Funeral Direct

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed : After this certification funeral director, within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

	1 - For State Registrar	State of N	iaryianu / L	•	ificate of L			-	Reg. No.	010	34415				
ın	1. Decedent's Name (First, Middle, Las	st)						2. Date of De Month	ath Day	Yea	3. Time of Death				
al -	Donna Claire Nov							Octobe	r 17	2010	3,27,0	1			
er	4a. Facility Name (If not institution, give			4	4b. City, Town, or	Location	of Death		4c. County of Death						
	Calvert Manor					ng S				Cec					
	5. Social Security Number 6. S 194–32–4709	ex □M2DXF	ige (In yrs. last birt		If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Bir (Month, Da	ay, Year)	(	Birthplace (State or Foreig Country)	ın			
	Usual Residence of Decedent		68	113.				Feb. 3	3, 194	42   Pennsylvania					
	10a. State 10b. County		10c. City, Town	or Loca	ition						10d. Inside City Limits	5			
ō	Maryland Cec:	<i>t</i> 1	D.								1 □ Yes 2 XNo	0			
ect	10e. Street and Number	T.T	K	LSIN	g Sun 10f. Zip Code				10a Citize	en of What	Gountry?				
		له مـ ۵			·	1011			rog. ottaza		oodinty.				
To Be Completed by Funeral Director	1881 Telegraph I	12. Was Deceder	t Ever in II S	13 W/s		1911	iain? (Sn	cify Vee or No	)- 14	USA Bace - Ar	merican Indian,				
Ë	1 Never Married 2 Married	Armed Forces	?	If Y	as Decedent of H res, specify Cuba	n, Mexica	n, Puerto	Rican, etc.)	,	Black, Wi					
by F	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates		1 [	□Yes 2MNo	Specify:				Specify:	17h 4 h -				
- Pa	15. Decedent's Ed			Decede	nt's Usual Occup	ation			16h Kind	d of Busines	White	_			
Set	(Specify only highest gra	ide completed)		(Give kil	nd of work done of NOT use retired	lurina mos	st of work	ng	Tob. rain	or Busines	33/IIIdd3ti y				
Ĕ	Elementary/Secondary (0-12)	College (1-4o		_	etary	,				Catho	lic School				
õ	17. Father's Name (First, Middle, Last)	)		CCL	ctary	18. Moth	er's Name	(First, Middle	*		116 2611001	_			
B	Donald Niccolls							ine Ad							
Ĕ,	19a. Informant's Name/Relationship (	Tyne. Print)	19h	Mailing	Address (Street					Town State	Zin Code)	_			
	Mary Novak-Caskey/Daughter 50 Barker Street #528, Mount Kisco, NY 10549  20a. Method of Disposition   20b. Place of Disposition (Name of Date   20c. Location - City or Town, State														
	1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 10/19/2010														
	4 □ Donation 5 □ Other (Specif		R. T.		rd Funer			P.A.	Risi	ng Sui	n, Maryland				
	21. Signature of Funeral Service Licer	isee		R .	Name and Addres	s of Facili ரி Fiir	<sub>ty</sub> neral	Ноте.	P.A.						
	Ril <sup>T</sup> . Foard Funeral Home, P.A. 111 S. Queen Street, Rising Sun, MD 21911														
	23a. art1. Enter thy disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only ne cause on each line.  Application of the property of the cause														
	Immediate Caus (Final disease or condition Somile dementing of Alsheimen's Tube														
	resulting in death)	a.  Due to (or a	s a consequence	of):	0, ,	£11,C11		Mic			Acr.>	_			
Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or a	s a consequence o	10											
Ē	Cause (Disease or injury that initiated events	C													
Exa	resulting in death) Last	Due to (or a	s a consequence	of):											
ca		- d													
edi															
3	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom					23	delivery							
ciar	in the past 12 months?		2 Fetal death at time of death		ctopic pregnancy Other (specify)				Day Year						
ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown	at into or dodn	Striet (opcony)											
占	Part II. Other significant conditions of	ontributing to death	but not resulting in	the und	erlying cause give	en in Part	l.	23e. Did	tobacco us	e contribute	to the cause of death?				
d b								10	Yes 2	No 3□	Probably 4 Unknow	'n			
etec			-									_			
nple.								24a. Was	psy	prior 1	autopsy findings available to completion of cause of	e			
S								perf 1 Yes	ormed?	death 1 □ Y	i? ′es 2∐No				
3e (	25. Was case referred to medical examiner?					26. Plac	e of Deat	n (Check only	one)						
0	1 Yes 2 No	Hospital: 1 ☐ Inpa	tient 2 ER/Ou	tpatient	3 DOA Oth	er: 40N	ursing Ho	me 5□Res	idence 6	□Other (S	pecify)				
i.	27. Manner of Death	28a. Date of Ir (Month, L		ime of	28c. Injur Wor	v at		28d. Describe							
atio	1 Natural 5 Pending 2 Accident investigation		.,	·43		Yes 2□	No								
iţi	3 Suicide 6 Could not be 4 Homicide determined	Zee. Place of I	njury - At home, fa	rm, stree	et, factory, office			28f. Location	Street and	Number or	Rural Route Number,	_			
ert	4 Li tottiloido	building,	etc. (Specify)					City or 10	wn, State)						
alC	29a. Certifier 1 Certifying Ph	nysician: To the be	st of my knowledge	, death o	occurred at the tir	ne, date a	nd place,	and due to the	cause(s)	and manner	as stated.	_			
Medical Certification: To Be Completed by Physician/Medical Examiner	(Check only 2 Medical Examone)	miner: On the basis and manner	of examination an	d/or inve	estigation, in my o	pinion, de	ath occur	red at the time	, date and	place, and	due to the cause(s)				
Me	29b. Signature and title of certifier				29c. Licens	e number		T	29d. Date	signed (Mo	onth, Day, Year)				
	mained				000		·~·			18/12					
						TXX	14		W	INCLES	)				

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

101 COLONI

Way, Rising Sun, MO

21911

10-07876
Manuel Oviedo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible? 34416

Amended 18 p	er	1- For State Registrar CS		or iviaryi		Certific					Re	eg. No.		
Physici Medical Exami		1. Decedent's Name ( Manuel		0viedc	)						Date of Deat Month October 1:		ır	3. Time of Death 1538 hrs
		4a. Facility Name (if n Western Mary		ive street and n	umber)			. City, Town, Cumberla		of Death		4c. County of Allegany		
Funeral Director		5. Social Security Nur 558-59-40		Sex 2 F	7. Age (Ir	n yrs. last bir L	thday) Yrs.	If Under 1 You Months Da	ear If Und		3. Date of Bir	th(MM/DD/YYYY	Foreig	hplace (State or n untry) CA
ow any			b. County		100	c. City, Town							R.	10d. Inside City Limits 1 Yes 2 No
Maryland 28a-f sh	<b>Funeral Director</b>	WV 10e. Street and Numb	Prest	on		Terra		10f. Zip Code			10	0g. Citizen of Wh	nat Cour	
with the ms 23a or be notifi	eral Di	102 Auror		12. Was De		er in U.S.			Hispanic Ori		fy Yes or No		- Ameri	can Indian, Black,
s after death ral", or ite	by Fun	3 Widowed 4 Divorced If Yes 2 No no Dates:					1 <b>X</b> Y	es 2 N	lo specify:	Mexi	Rican, etc.) White, e			ITE
36 in 72 hours han "natu	Completed	Elementary/Second			1-4 or 5+)	ted) 16a.	during mos	Usual Occup of working li Vaiter	pation (Give fe. DO NOT	kind of worl use retired	k done )	16b. Kind of Bu		•
21215-0036 buld be filed within 7 Mental Hygiene. marked other than e event, the Medica		12 17. Father's Name (Fi		t)	<u> </u>		V	valter				Re Maiden Surname JoAnna		rant
D 212. should be and Menta is market atic even	To Be	Wally Ovid	e/Relationship (			19			eet and Nun		al Route Num	ber, City or Tow	n, State,	
re, MD s 1 and 2 sho f Health and If iten 27 is		Wally Ovi	sition		rom State	20b. Place o	of Disposition	n (Name of o	Ave.	Terra	Alta,	WV 267 20c. Location -	64 City or	Town, State
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland benderment of Health and Mental Hygiene. Inportant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		Telloval Ion State					nberland Crematory 10/16/10 Cumberland MD  22 Name and Address of Facility David A. Burdock Funeral Hom							
Physician		23a. Fart I. Enter the claiflure. List only	disease, or com	plications that o	caused the	death. Do no	21 N	2nd	Stree	t, Oa	kland,	MD 215	50	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Fir or condition resulting	nal disease a		Death									
	iner	Sequentially list conditions, f any, leading to immediate cause. Enter Underlying Cause  Due to (or as a consequence of):												
cuted nd transit	I Examine	(Discuss or injury that events resulting in de	ath) Last	Due to (or as a	a conseque	ence of):								
60, ate be exe obysician a	Medical	UNPENDED  IF FEMALE:		AMENDED	outcome o	f pregnancy			_			23d Date of	delivery	
Division of Vital Records, P.O. Box 68760, To the Ropial or Attending Physician: The law requires that the death certificate be executed within 24 hours after deet. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/I	If FEMALE: 23d. Date of delivery 23d. Date of delivery 23d. Date of delivery 4 Pregnant at time of death 5 Other (Specify)  1 Yes 2 No 9 Unknown  23d. Date of delivery Month D  Other (Specify)											,	ay Year
P.O. E es that the c igned by the dedached	Ď	Part II. Other signification	ant conditions			t not resulting	g in the und	erlying cause	given in Pa	art I.				he cause of death?
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the rate death.  The Invector: After this certificate has been signed by led in by the funeral director, page 2 should be detact.	Completed						-				24a. Was a autops perfor	sy p m <u>ed</u> ? d		copsy findings available completion of cause of
ital Resident Ti	a	25. Was case referred examiner?	_	Hospital: 1	Inpatient	2 T EB/0	utpatient 3		oe of Death	(Check only	one)			
n of V nding Phys th. : After thi e funeral di	ion: To	1 Yes 2 27. Manner of Death 1 Natural	No Pending	28a. Date		28b.	Time of Inju	ry 28c. In	jury at Work	? 28	d. Describe h	Residence 6 L now injury occurre auto fixed obj		
Divisic tal or Atter rs after dea al Director	Certification:	2 Accident 3 Suicide 6 4 Homicide	Investiga Could no determine	t be 28e. Plac	e of Injury	- At home, fa	rm, street,			c. 28	or Town, St			ral Route Number, City
o the Hospi thin 24 hou o the Funer mpletely fil	Medical Co	29a. Certifier 1 Ce		ian: To the bes	st of my kno	owledge, dea				ace, and due	e to the cause	e(s) and manner and place, and d	as state	
F 3 F 8	Me	29b. Signature and titl	e of certifier		S				.M.E.			29d. Date signe October 16		
	4	30. Name and address Melissa Brass		completed caus		. ,	111 Per	n Street,	Baltimore	e, MD 21	201			
St Regist	ate trar	31. Date filed (Month,	Day, Year) 0 2010	32. Re	egistrar's S	ignature	New .							······································
DHMH 17 Rev 1/2 OCME 2006	_		OCME	Comme	- 10	OR	IGINAL	• •			· · ·			

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death October 11 Day Physician/ 201<sup>rea</sup> 8:50 Рм Norma Kathleen Parsons Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Cambridge Dorchester Chesapeake Woods 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🕅 F Dec. 26. 1921 Mary land 88 **Director** 214-10-0737 Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No Marvland Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21613 USA 525 Glenburn Avenue 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 Yes 2 No White Specify: 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Billing Clerk Hardware Store Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Bessie Wroton Wilson Shannon Warner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4345 Steele Neck Road, Vienna, MD 21869 Linda B. Willey/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Church Creek, Maryland Old Thinity Church Cemetery 10/15/2010 4 Donation 5 Other (Specify) 21. Signatur of Funeral Service License Zeller Funeral Home, P. O. Box 207 106 Main Street, East New Market, MD 21631 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, reading to infiniodiate cause. Enter Underlying Examine Justo (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical P.O. Box 68760 use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year 5 Other (specify) signed by the at d be detached for g 🗍 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Usinary 1 Yes 3 Probably 4 Unknown Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has page 2 s autopsy performed 2 Yes 2 No this certificate 1 Yes 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) director, Be Hospital Other: 1 Yes 2 XX ER/Outpatient 3 DOA ည 4 Very line 4 Residence 6 Other (Specify) 1 Inpatient 2 I funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After Natural Accider 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: Ai
completed filled in by the fu Investigation 2 Accident
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Eertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 44615 04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NARR 100 0 60,5 A. 31. Date filed (Month, Day, Year)

OCT 14 2010 Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 201 State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Romuald Gerard Patrick Russin October 14, 6:27 pm Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital Olney Montgomers Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** Months Days 1 🕱 M 2 🗆 F Hours D.C. **Director** 220-60-6117 60 Sept. Usual Residence of Decedent shov 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State , or items 23a or 28a-f sho aminer must be notified at Director MD 1 Yes 2 X No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 401 Royalton Road 20901 USA death v Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11, Marital Status Examiner Armed Forces?

1 Yes 2 No Black, White, etc. 1 X Never Married 2 Married <u>6</u> Baltimore, Maryland 21215-0036 hours after Specify: White If Yes Give 1 Yes 2 X No Specify 3 Widowed 4 Divorced "natural" Completed Year or Dates Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) the Jani tor Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Russin Marjorie Perry other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marjorie Russin/Mother 401 Royalton Road, Silver Spring, MD 20901 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Oct. 21. cemetery, crematory or other place) 1 🕱 Burial 2 🗆 Cremation 3 🗆 Removal from State any injury or Gate of Heaven Cemetery 2010 Silver Spring, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cor Pulmonale disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Chronic Obstructive Pulmonary Disease Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Due to lor as a consequence of The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Year Day Pregnant at time of death by the a a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I by Rectal Cancer Division of Vital Records, 1X Yes 2 □ No 3 □ Probably 4 □ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? certificate 1 ☐ Yes 2 ☐ No Yes 2 x No the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 X No 1 Inpatient 2 NR/Outpatient 3 DOA မ To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 Yes 2 No injury 5 Pending 1 X Natural Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3

State Registrar

DHMH 17 Rev 7/2009

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

18

14306

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

# 210

3. Registrar's Signature

29c. License number

Jagdish

534n

mo

29d. Date signed (Month, Day, Year)

OCH

Shesadn

20715

1615

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 23a per dr., g909, II/16/2010dhb Certificate of Death Reg. No. 1 - State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Detole 2 Day David 3 noma Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death of Maryland Medical timore Social Security Number Age (In vrs. last birthday If Under 24 Hrs 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 № M 2 🗆 F Months Days Min. Oct.30 54 218-62-9153 Director Mary Land Usual Residence of Decedent should be filed with the state of the state or 28a-f show 10a, State 10c. City, Town or Location 10d. Inside City Limits Directo Md. Washington Hagerstown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 140 W. Franklin St. Suite 300 21740 U.S.A 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 √2 No Specify. 3 Widowed 4 Divorced Specify: White Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Carpenter Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George L. Robinson Sr. Shirley M. Dickey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 1044 B Noland Dr. Hagerstown, Md. 21740 Robert J. Robinson Sr. (Brother) Date 28, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 0ct ☐ Burial 2<sup>4</sup> Cremation 3 ☐ Removal from State Smithsburg Crematory Smithsburg,Md. 4 ☐ Donation 5 ☐ Other (Specify) 2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 12525 Bradbury Ave. MO1414 J.L. Davis Funeral Home AWIS Smithsburg, Md. 21783 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. End Stage Liver Disease Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) 1 seu comanas Medical Due to (or as a consequence of) Examiner domana Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year signed by the a To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of page 2 s autopsy death? 1 ☐ Yes 2 ☐ No Yes 2 Division of Vital 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 hours after death.

•uneral Director: After the filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 2 🗌 No Accident Investigation 2 Accidence 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number RSident Physicia 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, Maryland : Il ene Lawis een 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 2010 1219 Рм Gary Paul Roark, Sr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 102 Miller Street Ceci1 E1kton 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F DEC 16. 1956 Months Days Hours Min. Maryland 53 Director 212-70-0471 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-1 shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 102 Miller Street 21921 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔼 No Black, White, etc. 1 Never Married 2 X Married \$ 1 Yes Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Completed White Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Automobile Transport Yard Man Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Paul Dee Roark Elizabeth Arvay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joanne M. Roark/Wife 102 Miller Street, Elkton, MD 21921 20a. Method of Disposition 20b. Place of Disposition (Name of TummacUlate Conception Cemetery 20c. Location - City or Town, State Department of I Important: If ite any injury or other October 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2010 Cherry Hill, MD 21. Signat he of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician/ disease or condition resulting in death) myocard Medical Due to (or as a conseque ce of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury bunial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death signed by the a g Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown cate has been sig page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s autopsy perform 1 Yes 2 No Yes 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 2 XX Other: 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work' 1 Yes 2 No Investigation Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

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State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

childse MP

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regist ar's Signature

West man St. 2/19te

29d. Date signed (Month,

261

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Physician/ Hutchinson Russell Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death WMHS-RMC Allegany Cumberland 9. Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday **Funeral** Jun 9 1 🗆 🕍 2 🗆 F PA Director 201-14-9113 86 Usual Residence of Decedent or 28a-f show 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked outher than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Allegany Cumberland 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 701 Furnace Streer Apt. 105 21502 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 3 - Widowed 4 - Divorced white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Manager of Accounting Heinz Co Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) James Russell Anne (Walker) Russell 19a. Informant's Name/Relationship (Type, Print) 19b. Maijing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 401 Teravista Parkway Apt. 1317 Round Rock TX Janet Hughes 78665 Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Offemation 3 Removal from State Scarpelli Funeral Home, P.A. 10/22/2010 Cresaptown MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Scarpell Full eral Home, PA 21. Signature of Funeral Service License 108 Virginia Avenue: Cumberland, MD 21502 23a. Part / Enter the disease, or complications that cauled the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ iopulmonary ar disease or condition Medical resulting in death) hi **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events ration Meumoni and resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 🕅 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? emphysemo 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical released
Yes 2 No Be 26. Place of Death (Check only one) Other: ပ္ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) . Date of injury (Month, Day, Year) 27 Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending 2 🔲 No Accident Investigation after death Director: / 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number completed filled in by determined City or Town, State 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certif 29c. License number 1007015 erson who completed cause of death (Item 23a) (Type, Print) Glenn St, Ste 300 Gum 31. Date filed (Month, Day, Year 32. Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 15, 2010 **Physician** 6:00 A.M Doy Douglas Sisler /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Garrett Oakland Nursing & Rehab. Center Oakland If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex Social Security Number **Funeral** Months Days Hours 1 M 2 □ F 220-32-3821 Feb 24, 1933 Director Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, its Medical Evantical must be notified at any injury or other traumatic event, its Medical Evantical must be notified at any once. 1 ∐Yes 272 No Director Friendsville MD Garrett 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21531 7323 Cranesville Road death v by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify: Specify. white 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Timber Truck Driver 8 th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be a Violet Uphold Jasper Sisler ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Leon Sisler/brother 192 Sisler Lane, Friendsville, MD 21531 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Oct 17, 2010 Country Side Crem. Davidsville, PA 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service Licensee 20.5 179 Miller St., Box 275, Grantsville, MD 21536 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Lectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 DNo 1 □Yes 2 No 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 28b. Time of Injury Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐Yes 2 ☐ No investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated.

State

31. Date filed (Month, Day, Year) **OCT 1** 9 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Richard A. Porter, DO, 311 N. Fourth St., Oakland, MD Registrar's Signature

Registrar

29c. License number

H0064705

29d. Date signed (Month, Day, Year)

Oct 16, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 13, 2010 Physician/ Carl P. Srsic 12:55 p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** Days 1 X M 2 □ F Months Hours July 16, 1960 168-52-9865 50 PΑ **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 ☐ Yes 2X No Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral 9501 Monroe Street 20910 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc Completed by Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: If Yes Give 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other the any injury or other traumatic event, the once. 12 Mail Room Clerk Shipping Be 18. Mother's Name (First, Middle, Maiden Surname)
Catherine Theresa Trubic Father's Name (First, Middle, Last)
Edward Peter Srsic, ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kathleen Srsic-Stoehr/Sister 8758 Brook Road, McLean, VA 22102 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 18, Oct. Gate of Heaven Cemetery 2010 4 Donation 5 Other (Specify) Silver Spring, MD 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, occumplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition resulting in death) Asriration Pneumonia weeks Medical Examiner Seizure Disorder weeks Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) 50 yrs Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-trinsit Down's Syndrame and that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Year ò Month Day Pregnant at time of death 2 No 9 Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Dysphagia, Asthma, Dementia 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 Yes 2 No Yes Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner's Hospital Other: 1 Nnpatient 2 ER/Outpatient 3 DOA 1 🗌 Yes 2 🙀 No မှ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work 1 X Natural 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Acciden Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Tertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I only one) D 0065485 Auparrich RSW 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

Barbara Supanich, MD

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31. Date filed (Month, Day, Year,

Registrar's Signa

1500 Forest Glen Road, Silver Spring, MD 20910

barker

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 14 2010 Physician/ 9:03A. Bates Shanks James Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 3112 Gracefield Road, #117 Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Ohio (ntry) 1 X M 2 □ F 93 Hours Jume**17**% **19**17 281-16-6055 Director Usual Residence of Decedent show or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director Montgomery Marvland Silver Spring 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be I Funeral United States 20904 3112 Gracefield Road, #117 permit. Page 1 and 2 should be filed within 72 hours after death v permit. Page 1 and 2 should be filed within 72 hours after death v important: If item 27 is marked other than "natural", or items any injury or other traumatic event; the Medical Examinar mus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 X Yes 2 If Yes, Give Black, White, etc. 1 Never Married 2 Married 호 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Year or Dates. WII White Specify: 3 🗌 Widowed 4 🗆 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) University of Maryland Professor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lucile Mary Bates ည William B. Shanks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3112 Gracefield Road,#117 Silver Spring, MD 20904 19a, Informant's Name/Relationship (Type, Print) Barbara B. Shanks -wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory 10/14/2010 20a. Method of Disposition
1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Signatur Fineral Service Bonard V. Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1 Inter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Vears Immediate Cause (Final Vascular Dementia Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Tuneral Director. After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the built completed filled in by the funeral director, page 2 should be detached for use as the built. Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Prostate Cancer 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed? Yes 2 X No 1 ☐ Yes 2 🔀 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4  $\square$  Nursing Home 5 X Residence 6  $\square$  Other (Specify, 2 X No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) 20 D36716 October 14, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Andrew Kundrat, M.D. 3110 Gracefield Road Silver Spring, Maryland 20904

State

Registrar

Registrar's Signatur

OCT 15 2010

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ll	5		For State		S	tate of M	1arylar			nt of F te of E			lental Hy	•	2010	21.1.25		
			Registrar  1. Decedent's Name	e (First, Middle	, Last)			Cer	unca	le oi L	Jeau	<i>'</i>	2. Date of De	Reg. N	<u>• U   U</u>	3. Time of Death	<u>J</u>	
	Physicia		Lucy Schi	ram									Month Octol	D	11, 2010		М	
	Medic Examin		4a. Facility Name (if	4b. Cit	y, Town, or	Locatio	n of Death	00000	-	c. County of Deat		_						
			Riderwood Village								Spri				Mc	ntgomery		
	Funeral		5. Social Security Nu 064-18-22		6. Sex 1 ☐ M			last birthday) Yrs.	If Und Months	er 1 Year Days	If Und		8. Date of Bir (Month, Da	y, Year)	Co	thplace (State or Foreig untry)	gn	
	Director		Usual Residence of		*		86	110.			<u> </u>		January	7 11	1924 A	ustria	_	
	land show	tor	10a. State	10b. County			10c. Cit	ty, Town or Loc	ation							10d. Inside City Limit	ts	
	Mary 28a- notifie	irec	MD		tgome	ry		Silver								1 □XYes 2 □ 1	No	
	72 hours after death with the Maryland n "natural", or items 23a or 28a-f show ledical Examiner must be notified at	Funeral Director	10e. Street and Num			1		110000		ip Code				10g. C	Citizen of What Co	untry?		
	ems 2	une	3160 Grac	cefield		Vas Decedent			$\overline{}$	20904 edent of Hi	spanic (	Origin? (Spe	cify Yes or No-		USA 14. Race - Ame	rican Indian		
ဖွ	ter de , or it	by F	1 Never Marri	ed 2 🗌 Mari	ied 1	rmed Forces?		li li	Yes, spe	ecify Cuba	n, Mexic	an, Puerto			Black, White			
21215-0036	ursaf tural" al Exa	ted	3 🔀 Widowed		Y	Yes, Give ear or Dates.		_   1	∐ Yes	2 <b>X</b> No	Speci	ify:			Specify: W	Mite		
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212	within giene.	S	Elementary/Seco	onday (0-12)	C	ollege (1-4 or	5+)	Seams		se retired)				  प	ashion			
	filed val Hyg		17. Father's Name (F	First, Middle, L	ast)			1 Deams	CICL		18. Mo	ther's Name	e (First, Middle,					
ylar	ild be file Mental I <b>iarked o</b> atic eve	욘	Friedri	ch Jedl	insky	7					Ma	lvine	Weiss					
Maryland	permit. Page 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exaronce.		19a. Informant's Na			,		,	_						or Town, State, Zip	,		
e,	and 2 Health em 2; ther t	-	Steven H.		111/5011	L	20h F	Place of Dispos			et,					ington, DC	,	
Baltimore,	Page 1 nent of ant: If it ıry or o		1 XBurial 2	☐ Cremation		oval from State		cemetery, crem	atory or	other plac			8/2010		_ocation - City or			
altir	permit. Page Department of Important: If any injury or once.	1	4 ☐ Donation  21. Signature of Fun	eral Service I	icensee		Gai	22	Name a	and Addres	s of Fac	Edwa	rd Sage	1 F	uneral D	, Maryland	1	
ä	permi Depar Impoi any ir		> MC	Gree	nhu	x Ma	215	77	1091	Rocl	kvi1	le Pi	ke, Roc	kvi	lle, Mar	yland 2085	32.	
			23a. Part 1. Enter the shock, or hear	ne disease, or t failure. List o	complication	ons that cause	d the deat	h. Do not ente	r the mo	de of dying	g, such a	as cardiac c	r respiratory ar	rest,		Approximate Interval Between		
2	Physician/		Immediate Cause (F disease or condition			CAD										Onset and Death		
4	Medical Examiner		resulting in death)		<b>r</b> "-	Due to (or as	a consequ	uence of):										
		ē	Sequentially list cor if any, leading to im cause. Enter Under	nditions,	b. —	Valvul Due to (or as		art Di	seas	e								
	T ded	Examiner	Cause (Disease or i	injury	4	Alzhei		acrioc oi).										
	be executed ician and burial-transit		that initiated events resulting in death) L		с	Due to (or as		uence of):										
9	Hospital or Attending Physician: The law requires that the death certificate be executed hours after death.  Funeral Director: After this certificate has been signed by the attending physician ancested filled in by the funeral director, page 2 should be detached for use as the burial-tra	dical		,	d													
Box 68760	eath certificate by attending physic I for use as the b		IF FEMALE:		220 If	vas outcome	of progna	anou.										
X	ath ce attend for us	cia	23b. Was decedent past 12 m	nonths?	1	yes, outcome Live Birth Pregnant	2 🗌 Feta	aldeath 3 🗆	Ectopic Other (s		у				23d. Date of del Month	ivery Day Year		
œ.	the de	hysi	1 Yes 2 9 Unknown	. No		Unknown			O 1.10. (c	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,								
P.O.	es that the des signed by the a be detached t	<u>ا ځ</u>	Part II. Other signifi	cant conditio	<b>ns</b> contribu	ting to death I	out not res	ulting in the ur	nderlying	cause giv	en in Pa	rt I.	23e. Did to	bacco	use contribute to	the cause of death?		
ds,	requires been sig should b	ted			-								1 🗆	Yes 2	P □ No 3 □ Pr	obably 4 🛭 Unknow	٧n	
200	aw re as be	Completed by											24a. Was	sy	prior to d	opsy findings available completion of cause of	e f	
Re	cate has												1 🗌 Yes	rmed?	death?	2 🗆 No		
ital	sician: The certificate irector, pag	mσl	25. Was case referre examiner? 1 \sum Yes 2 \sum_{\textbf{x}}		Hospit	al:				Otho	r·	eath (Check				Assisted	$\dashv$	
of V	g Phys er this eral dir	ے :	27. Manner of Death			Ba. Date of inju	ıry	ER/Outpatien 28b. Time of		28c. Injury	at		me 5 ∐ Resid 28d. Describe h		6X Other (Speci ry occurred	ify) Living	$\dashv$	
ou	ending eath. rr. Afte re fun	ficat	1 ☑XNatural 2 ☐ Accident	5 Pendin	ation	(Month, De	iy, Year)	injury	М	work	? Yes 2			•	•			
Division of Vital Records,	or Atter ter de irecto	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 🗀 Could r determi		e. Place of Inj building, et		me, farm, stre	et, facto	ry, office			28f. Location (S City or Tow		nd Number or Rur	al Route Number,		
ā	pital o		OC- Contilled 4		DI	T												
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completed filled in by the funeral	Medical	(Check 2	Medical E	caminer: O	n the basis of e	examination	n and/or investi	gation, in	my opinio	n, death	occurred at	the time, date a	nd plac	nd manner as sta e, and due to the c (s) and manner as	ause(s) and manner sta	ated.	
	To the within 2 To the comple		29b. Signature and ti		nuise Flat	(	pest of m		29	c. License	number			29d. Da	ate signed (Month	, Day, Year)	$\neg$	
	15		h	Mores	].	ta	de	- at		All.	26	33		10	11/10			
			30. Name and addre	ss of person v	ho comple	ted cause of c	death (Item	23a (Type, Pi	int)			. (	1 01	~	5 1	ischen ms	$\int$	
			31. Date filed (Month	Wan Year	e H	aclin Backet	aris Signa	VIV.	54	0 6	raci	enel	a jun	, _	7,104 7	pring, mD	$\Box$	
	Stat Registra	_	00		2010	De w		. Apar								707	ĺ	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ James Minor Sachlis October 2010 11:00 PM Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Casey House Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Unde 8. Date of Birth **Funeral** If Under 24 Hrs. Birthplace (State or Foreign Country) 1 🖾 M 2 🗆 F Months Hours Min (Month, Day, Year Director 220-40-4550 68 1942 Washington, DC 4. Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3325 Clay Street 20902 United States within 72 hours after death 11. Marital Status 12 Was Decedent Ever in LLS 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 XNo Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify. Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NCT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Professor of Finance George Washington Univ. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sachlis Gus Ruby Flack 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wendy E. Schaeffer/ POA/friend 7403 Colross Glen Drive King George, Virginia 22485 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date permit. Page 1 a Department of I 1 Burial 2 X-Cremation 3 Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 10/16/2010 Woodbine, Maryland 21. Signature of Funeral Service Licens Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 thomas M00957 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) pni Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or imjury that initiated events resulting in death) Last the burial-transi Due to (or as a consequence of): attending physician Physician/Medical that the death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Month been signed by the a should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ COPD Records, Completed 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N certificate ☐ Yes 1 Yes Hospital or Attending Physician; 25. Was case referred to medical Division of Vital Be completed filled in by the funeral director, 26. Place of Death (Check only one) 1 🗌 Yes Other: 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Cther (Specify) Hosave House 27 Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending injury after death. 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) V 37142 10-14-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 Rockville MD

DHMH 17 Rev 7/2009

State

Registrar

Coleman

G.

31. Date filed (Month, Day, Year)

**Yiccard** 

32. Registrar's Signature

Tenewa

1355

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Physician/ october 15, 2010 9:45 A M Κi Suk Speer Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Montgomery Burtonsville Sanctuary at Holy Cross 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) Funeral (Month Day, Year) OV 24, 1931 Min 1 🗆 M 2 🛣 F South Korea 78 Nov 462-84-9286 **Director** Usual Besidence of Decedent 10d. Inside City Limits 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director 1 🗆 Yes 2 🗐 No Maryland Prince George's Adelphi 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6 Funeral items 23a United States 20783 7914 West Park Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 No Black. White, etc. ori 1 Never Married 2 Married þ Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 No Specify Specify If Yes, Give "natural", 3 Widowed 4X Divorced Asian Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done life. DO NOT use retired) during most of working and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Restaurant Manager Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be fi h and Mental Jum Bong Chung Sup 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 st. Department of Health ar Important: If item 27 is any injury or other trau Silver Spring, Maryland 20906 John Vea Speer/son 2822 Aquarius Avenue Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Final Journey Crematory 10/18/2010 Woodbine, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lices Coing Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Thomas M00957 same 23a. Part DEnter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final ancer mal as Pnysician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Due to or as a consuluence of cause. Enter Underlying Cause (Disease or iinjury signed by the attending physician and a be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Live Birth 2 - Fetal death Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Yes 2 No 1 | Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, should peen 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performed page 2 has 1 ☐ Yes 2 ☐ No this certificate Yes 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) the funeral director. Be Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury\_at 28d. Describe how injury occurred Certificate: After 5 Pending work 1 Natural 1 Yes 2 No Accident Investigation 24 hours after deat Funeral Director: 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completed (Check 3 [ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sule 203 Baltimone Smith Ave., 2835 Na

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Monta

Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

		State of Maryland / Departme	nt of Health	and Men	tal Hygie	ne	01100			
_		1 - State Registrar Certifica	te of Death		Reg.	N2010	34428			
Physicia	ın/	1. Decedent's Name (First, Middle, Last)  Margaret Ann Schmidt			Date of Death Month	Day Year	3. Time of Death  9: 20 / M			
Medic Examin			y, Town, or Location	n of Death		4c. County of Death				
		Coastof Hospice at the lake	Sal: 530	ury		Wice	mico			
Funeral Director		5. Social Security Number   6. Sex   7. Age (In yrs. last birthday)   1		er 24 Hrs. 8. D Min. Ma	Date of Birth Month, Day, Yea TCh 29,	9. Birth	place (State or Foreign Tand			
		Usual Residence of Decedent								
uyland a-f sho iled at	Director	10a. State   10b. County   10c. City, Town or Location   Maryland   Dorchester   Hurlock					10d. Inside City Limits 1 ☐ Yes 2X No			
or 28;			Zip Code		10g.	. Citizen of What Cou				
s 23a	Funeral	3527 Cabin Ridge Road	21643	3		USA				
or item	y Fui	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 ★ Married  12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ★ No	edent of Hispanic Or ecify Cuban, Mexica	origin? (Specify Y an, Puerto Rican	res or No- n, etc.)	14. Race - Ameri Black, White,				
flied within 72 hours after death with the Maryland all Hygiene.  Other than "natural", or items 23a or 28a-f sho went, the Medical Examiner must be notified at	ed by	3 Widowed 4 Divorced Sear or Dates.	2 X No Specify	fy:		Specify: White				
"2 hou "natu edical	Completed	15. Decedent's Education 16a. Decedent's Us (Specify only highest grade completed) (Give kind of w	ork done during mos	ost of working	161	16b. Kind of Business Industry				
/ithin /ithin /iene.	Con	Elementary/Seconday (0-12) College (1-4 or 5+) life. DO NOT us.  Homema				Own Hon	ne			
should be filed within 72 hours after death with the Maryland and Mental Hygiene.  and Mental Hygiene.  are anaked other than "ratural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	o Be	17. Father's Name (First, Middle, Last)		ther's Name (Firs		len Surname)				
ylan	ျ	Walter Ben Dillian		artha Th						
Te, Mal yla 1 and 2 should be of Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship ( <i>Type, Print</i> )  19b. Mailing Addres  Eugene K. Schmidt/Husband  3527 Cabi				y or Town, State, Zip MD 21643	Code)			
of Health of Health fitem 27		20a. Method of Disposition  1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State  20b. Place of Disposition (Na cemetery, crematory or	ame of	Date		c. Location - City or T	own, State			
Page 1 tment of tant: If it jury or o		4 Donation 5 Other (Specify) Maryland Vet.	Cem.	10/20/2		eulah, Mar				
permit. Page 1 Department of Important: If is any injury or of once.		22. Name a Ze I Le 106 M	and Address of Facil r Funeral lain Stree	L Home, et, East	P. O. I	Box 207 arket, MD	21631			
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mo shock, or heart failure. List only one cause on each line.	ode of dying, such as	s cardiac or resp	oiratory arrest,		Approximate			
Ph_sician/ Medical		resulting in death)	cell l	ung (	rance	er	Onset and Death			
Examiner		Du To (of as a consequence of).								
T #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury								
be executed sician and burial-transit	Exan	Cause (Disease or linjury that initiated events c. Due to (or as a consequence of):			<u> </u>					
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rtificate ing phy e as th	/Med	IF FEMALE:								
eath certificate battending physical for use as the k	sician/Med	23b. Was decedent pregnant in the past 12 months?  1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic to the past 12 months?  4 ☐ Pregnant at time of death 5 ☐ Other 6				23d. Date of deliving Month	very Day Year			
that the dea led by the a	Physi	1   Yes 2 X No 9   Unknown								
ss that igned be def	۾	Part II. Other significant conditions contributing to death but not resulting in the underlying Coronary Othery Disease		rt I.		co use contribute to t	he cause of death?			
v requires the speed signer should be a	ompleted	Essential Hypertension			24a. Was an		ppsy findings available			
The law ate has page 2:	omo	The House			autopsy performed 1 Yes 2	? death?	ompletion of cause of			
cian: T cian: T ertifica ector, p	Be C	25. Was case referred to medical examiner? Hospital:		eath (Check only		TI ICO				
Physician: This certificantal director,	၉	1  Yes 2 No	DOA Other: 4 \( \subseteq \) N  28c. Injury at		5 Residence	e 6 X Other (Specif	Hospice			
nding l ath. r. After e funer	icate	1 X Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation M	work? 1 \sum Yes 2		Describe now ii	ijury occurred				
or Attending Physician: The law requires that the death certificate after death.  Incord after this certificate has been signed by the attending phy in by the funeral director, page 2 should be detached for use as the	Certificate:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factor building, etc. (Specify)	ory, office		ocation (Street Dity or Town, St	t and Number or Rura tate)	l Route Number,			
To the Hospital or Attending within 24 hours after death.  To the Funeral Director After completed filled in by the fun	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of my knowledge, death occurred a Medical Examiner: On the basis of examination and/or investigation, in	in my opinion, death o	occurred at the ti	ime, date and pl	ace, and due to the ca	ause(s) and manner stated.			
To the within To the compl	Σ		9c. License number		29d.	Date signed (Month,	Day, Year)			
			D 2950	05	/	10-16-	10			
-	-	ad. Name and address of person who completed cause of death (Item 23a) (Type, Print)  GREGORIO M. BELLOSO: 5302 CHINA	BERRY D	R, SA	LISBU	RY, MD =	21801			
Star Registra		31. Date filed (Month, Day, Year) 32. Reflistrar's Signature	r)	,						
		//								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 2 (Certificate of Death Reg. No. State
 Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2301 M 2010 √ln 11+0 NV N 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Maryland 12/28/1982 Director 219-04-0362 27 Usual Residence of Decedent or 28a-f shov 10c. City. Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 X Yes 2 □ No Maryland | Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12701 Beaverdale Lane 20715 U. S. A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Was Deceden 2. Armed Forces?

1 Yes 2 No Black, White, etc. 1 X Never Married 2 - Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White Specify: "natural", 3 Widowed 4 Divorced Completed Year or Dates. permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medicall once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Chef Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Glenn Patrick Stewart Patricia Ann Caracciolo 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenn P. Stewart/Father 12701 Beaverdale Lane, Bowie, Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/21/2010 Baltimore Washington Crematory Laurel, Maryland 22. Name and Address of FacilityRobert E. Evans Funeral Home, 21. Signature of Funeral Service Licensee 400 16000 Annapolis Road, Bowie, Maryland 20715 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Multiple Drug Intoxication Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, harry, loading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events CERTIFICATION APPROVED BY MEDICAL EXAMINER Physician/Medical Examiner d consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FFMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Year Day Pregnant at time of death 1 Yes 2 L 9 Unknown 2 🗆 No Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 ☐ Yes 2 ☐ No Be ( 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes Hospital Other: 은 2 1NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury Found, Day, Year) 09/28/2010 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Subject 1 Natural 2 Accident 3 Suicide Found: 8:00 a.M 5 Pending ingested multiple drugs 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) **Home** 28f. Location (Street and Number or Rural Route Number, City or Town, State) 12701 Beaverdale Lane, Bowie, MD Homicide determined 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis of examination and/or investigation, in this your investigation in this your investigation in the your investigation in this your investigation in the your i 3 29b. Signature and title of certifier 2143 o complete cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year) 0CT 15 2010

32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene	04	4 0

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Examine								y, Town, oi kvill	r Location	of Death			4c. County of Death  Montgomery			
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1 and 1 and of Hea	ı	20a. Method of Disposition	b. Place of Disp	osition (N	ame of			Date			City or Town, State					
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permit. Page 1 Department of Important: If i any injury or once.	ı	21. Signature Funeral Service		11/	/				ss of Facili		nowden			•		
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that the	2	Part II. Other significant conditi	ons conti	ributing to o	death but not	resulting in the	underlying	g cause gi	ven in Part	: I.	23e. Did	tobacco us	se contribu	ite to the	e cause of deat	h?
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DIVISION OI tal or Attending P rs after death. al Director: After ti ed in by the funera	Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern			e of Injury - A ing, etc. (Spe	t home, farm, st	reet, facto	ory, office			28f. Location (		Number o	or Rural I	Route Number,	
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To the Hospital or Attending Physician: The law requires that the death c within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the atten completed filled in by the funeral director, page 2 should be detached for u.	Medical	(Check 2 Medical I	Examine	r: On the ba	sis of examina	owledge, death ation and/or inve	stigation, i	n my opinio	on, death o	occurred at	t the time, date	and place,	and due to	the cau	se(s) and manne	er stated.
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2		100000	<u></u>	111	VICI	CENI		1432	-OT			TO/ 1	-4/ TO			
		30. Name and address of person Deborah Miller						Rockv	ville	, MD	20850					
State		31. Date filed (Month, Day, Year)		32. F							-					
Registra		OCT 18	2010	Den	una	gnature	Sec.									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 14 2010 7:00 Maxine Jordan Scott Рм Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gaithersburg Montgomery Wilson Health Care Center 5. Social Security Number If Under 1 Year I If Under 24 Hrs 8. Date of Birth (Month, Day, June 29 **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2**X** F Months Days Hours **Director** 577-22**-**3566 89 Yrs Virginia 1921 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County with the Maryland 10c, City, Town or Location Director 10d. Inside City Limits MD Montgomery Gaithersburg 1 Yes 2 X No 10f. Zip Code 20877 10e, Street and Number ō 10g. Citizen of What Country? ıral", or items 23a o Examiner must be Funeral 301 Russell Avenue United States Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: "natural", Completed 3 Widowed 4 Divorced Specify White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) pernit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Congressional Aide Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Asa L. Jordan Stella Tysinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John L. Scott/ Husband 301 Russell Avenue, Gaithersburg, MD 20877 20b. Place of Disposition (Name of 20a, Method of Disposition 20c. Location - City or Town, State Metropolitan or other place, 1 
Burial 2 
Cremation 3 
Removal from State October 15 2010 Alexandria, VA 4 Donation 5 Other (Specify) Crematory 22. Name and Address of Facility DeVol Funeral Home, 10
Gaithersburg RACUA tuver 10 East Deer Park Drie, MO1117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Cerebrovascular Disease disease or condition Years Medical resulting in death) Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or ilnjury that initiated events resulting in death) Last Years Examiner Due to (or as a consequence of) signed by the attending physician and d be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 💢 No Dav Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Completed 1 ☐ Yes 2 🟋 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an in 24 hours after death.

The Funeral Director: After this certificate has labeled filled in by the funeral director, page 2 s autopsy Yes 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 😾 No Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie within 2

To the F

complet 3 [ only Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. re and title of Signat certifie 29c. License number 29d. Date signed (Month, Dav. Year)

Registrar
DHMH 17 Rev 7/2009

State

m

John Melnick, 911 Russell Avenue, Gaithersburg, MD 20879

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year,

OCT 18

D19294

October 15, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) October Physician/ 2010 0530 A M Nancy Roseanna Scott Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Ceci1 E1kton Laurelwood Care Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month Day, Year) ay 27, 1935 1 □ M 2 🛛 F Months Days Hours Min Maryland 215-30-5330 75 **Director** Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State with the Maryland Director 1 X Yes 2 No Maryland Ceci1 E1kton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral United States 21921 706 North Bridge Street permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces 1 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married <u>გ</u> Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 🗌 Widowed 4 🗆 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) In Her Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Milford Marshall Wyre Ada Rockey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 706 N. Bridge Street, Elkton, MD George W. Scott/Husband injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition October 28 1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from State West Chester, PA R. A. Ferris & Co., Inc. 4 Donation 5 Other (Specify) 2010 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licensee any 103 W. Stockton Street, Elkton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Coronary years Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Exami Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and -transit Due to (or as a consequence of) the attending physician and for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Dav Year signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 Yes 2 No death? 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ည 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work?
1 Yes 2 No 5 Pending M Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D0023322 Jackder & MD 10.25,2010. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. S. SACHDEV MD 126 A.E. Hook Elkton MD 21921

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registra s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5:35 A. M Year William Benjamin Shank October Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Williamsport 320 S. Artizan St. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) ept.12,1 1**X**□ M 2 □ F 75 Months Hours **Director** 214-34-0610 Maryland Usual Residence of Decedent or 28a-f shov notified at show 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director Williamsport Md. Washington 1 🕅 Yes 2 🗆 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be r Funeral 320 S. Artizan St. 21795 U.S.Awithin 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. ð 1 Never Married 2 X Married 2 No Baltimore, Maryland 21215-0036 ☐ Yes If Yes, Give Year or Dates 1 ☐ Yes 2√2 No Specify: White Specify: Completed 3 Widowed 4 Divorced the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) Machine Operator Brick Co. it. Page 1 and 2 should be filed with thrent of Health and Mental Hygien rtant; If item 27 is marked other the njury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ഉ Benjamin Shank Grace Houser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 320 S. Artizan St. Williamsport, Md. 21795 Jean C. Shank (Wife) Department of Health Important: If item 27 any injury or other to once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Oct. 26, Smithsburg, Md. Smithsburg Crematory 2010 Signature of Funeral Service Licensee 22. Name and Address of Facility 12525 Bradbury Ave. MO1414 J.L. Davis Funeral Home Smithsburg, Md. 21783 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause a geach line. Immediate Cause (Final month on the 21 Physician/ disease or condition Medical resulting in death) ue to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to for as a purpose unince of cause. Enter Underlying Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed and tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Dav Year Pregnant at time of death 9 Unknown the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available 24a. Was an After this certificate has prior to completion of cause of death? autopsy page Yes 1 Yes 26. Place of Death (Check only one) funeral director, Be 25. Was case referred to medical Hospital 2 No Other: 1 Tyes P 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 4 

Nursing Home 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation after death the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined 24 hours a Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatur 29d. Date signed (Month)

DHMH 17 Rev 7/2009

Registrar

ath (Item 23a) (Type, Print)

32. Registrar's Signature

ss of person who compl

31. Date filed (Month, Day, Year)

WD0052131

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 922 A M lean /Medical a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death County of Death Examiner Momoria 7. Age (In yrs. last birthday 101701 Birthplace (State or Foreign Country) 8. Date of Birth Social Security Number Funeral Year 1 M 2 F Months Director Usual Residence of Decedent cermit. Pat es 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydene.

Important: if item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Exeminer must be notified at the model. 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Funeral Director Grant 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Box 147 26707 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2 No <u>ک</u> Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nurses Aid Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ William Starkey Mindia Hess 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Willis L. Turner-Husband PO Box 147, Bayard, WV 26707-0147 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 10/20/2010 Bayard Cemetery Bayard, WV 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility David A. Burdock Funeral Home P.A. 21. Signature of Funeral Service Licenses 21 N. 2nd St, Oakland, MD 21550 23a. P. 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CORY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-transi Due to (or as a consequence of): attending physician for use as the buria Physician/Medical the IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 1 Nes 2 No 3 Probably 4 Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy perform certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ₺No 1 \$\times\$Inpatient 2 \$\subseteq\$ ER/Outpatient 3 \$\subseteq\$ DOA Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OCT 2 0 2010

32. Registrar's Signature

Richard Porter, 311 North Fourth St, Suite 1, Oakland, MD 21550

3altimore, Maryland 21215-0036

law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

Hospital or Attending Physician: The

H0064705

10/17/2010

Registrar DHMH 17 Rev 7/2009

State

Box 68760

P.O.

Records,

**Division of Vital** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra MEND#230+231+TiperMD, 10/15/10, BMN, MCDertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9:15 PM Sally Ann 2010 Oct. 7 Thompson Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Dayton MillRA 14305 Triadelphia If Under 1 Year If Under 24 Hrs.

Davs Hours Min. 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Country) 1 M 2 XF 81 Diech, Day, 4 Director 578-30-824 1928 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov amy bigny or other traumatic event, the Medical Examiner must be notified at on a. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Dayton Howar 1 🗆 Yes 2 📈 No MD 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A 21036 Was Decedent Ever in U.S. . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Hom Homemake Own 12 17. Father's Name (First, Middle, Last)
11. Illiam Roscorla Be 18. Mother's Name (First, Middle, Maiden Surname) Catherine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) rl A. Thomoson Dayton MD 21036 nusb Triadelphia 14305 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cem 20c. Location - City or Town, State Date ■ Burial 2 ☐ Cremation 3 ☐ Removal from State Silver Spring, MP Oct. 12, 2010 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 500 university Blvd. W. Silver spring 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Hm. Inc NO 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betw Onset and De shock, or heart failure. List only one cause on each Acute/ Chronic Renal Failur Immediate Cause (Final Physician/ disease or condition resulting in death) Chrowite 3 000 Medical Due to (or as a conse uence of: MONOCLO, I Gammopathy Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and been signed by the attending physician and should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Anemia 23e. Did tobacco use contribute to the cause of death? Completed by HBP 2 No 3 Probably 4 Unknown ence 1 Tes Cancer Effusion 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has autopsy 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗹 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral or 27. Mann Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred ✔ Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of exa Certifying Nurse Practioner To the best fon and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 [ dge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 0 26246 29b. Signature and title of certifier 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles Shee han, MD 1029 10298 Baltimore Natil Pike, Ellicott City 31. Date filed (Month, Day, Year) State 15 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-34437 For State RegistrayEND#5perFH, 10/18/10, BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ of the May Araline Ugarek AM 260 1020 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 2 Social Security Number 88 . Age (In yrs. last birthdav If Under 1 Year 8. Date of Birth (Month, Day, April 2 **Funeral** If Under 24 Hrs. 9. Birthplace (State or Foreign 1 🗆 M 2 🗓 F Months Days Hours Min. Pennsylvani Director 79 1931 Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery 1 🗌 Yes 2 🔽 No Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ems 23a or r must be Funeral 12801 Sage Terrace 20874 United States ortant: If item 27 is marked other than "natural", or items injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify. 3 X Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Electrial Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Melvin Stackhouse Erma Swisher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary Francis Ugarek -son 12801 Sage Terr., Germantown, MD 20874 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) LifeLegacy Foundation 10/13/2010 Tucson, Arizona 21. Signature of Funeral Service 22. Name and Address of Facility Thibadeau Mortuary Service, p.a. M00956 Park Ave., Gaithersburg, MD 20877 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Filysician anome disease or condition cens Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): physician sthe burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the buriel. Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Day Year signed by the a Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No certificate 1 Yes 2 No Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗆 Yes 2**X** No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of the funeral place on pleted filled in by the funeral completed filled in by the funeral place. 5 Pending work 1 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 [ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature 19453 npleted cause of death (Item 23a) (Type, Print) Alan S. Chanales,

Registrar DHMH 17 Rev 7/2009

State

30. Name and address

Shad Day, Year)

5

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 17, 2010 PM allis Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Egle Nursing and Rehab Center Lonaconing Allegany | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | (Month, Day, Year) | May 08, 1935 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 M 2 XF Country) Maryland Director 218-30-0167 75 Usual Residence of Decedent fshow permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-i show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Allegany Lonaconing 1 Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 57 Jackson Street 21539 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16h Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ William Harrison Donald Nellie Marie Whiteman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Keith Wilt - Son 15 High Street, Lonaconing, Maryland, 21539 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State October 20 1 D Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Green Cemetery Lonaconing, Maryland 4 Donation 5 Other (Specify) 2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A. Mehlil Lonaconing, MD 21539 8 East Main Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death HRUNIC OBSTRUCTIVE LUNG Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Dua to for as a consequence of physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🔀 No Month Day Year Pregnant at time of death signed by the a d be detached f 1 ☐ Yes ∠ p 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ARTERIAL Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖗 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? 1 🗌 Yes 2 🗌 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗆 Yes 2 🙀 No ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 29c. License number 2690 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 925 Bishop Walsh Road, Cumberland, Maryland

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Box 68760

P.O.

Division of Vital

10-07728 Xiuwen Wang Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Xiuwen Wang		1- For State Registrar	St	ate of I	viaryiano		artment ( e <i>rtificate (</i>			a Men	ital Hy	/giene	Reg. N	2010	34439		
Physicia	an/	1. Decedent's Name		le,Last)			_					2. Date of D	eath Da	ıv Year	3. Time of Death		
Medical Exami	ner	Xiuwen W		n. give stre	et and numbe	r)	-	4b. Cit	y, Town, or I	Location	of Death	October	8, 20	010 4c. County of Dea	0014 hrs		
		Suburban Ho		, g		.,			thesda		0, 2000.			Montgomery			
Funeral		5. Social Security No	umber	6. Sex	7. A	ge (In yrs.	last birthday)	_	Inder 1 Year		er 24Hrs. s Min.	8. Date of	Birth (N	Fore	Birthplace (State or		
Director		None		1 M	2 X F		28 Y	rs.	Days	Hours	J WIII.	May .	13,1	982	CountryChinese		
any	ŀ	Usual Residence of 10a. State 1	10b. County			10c. City	, Town or Loc	ation							10d. Inside City Limits		
and F show	ō	Maryland :		omery		Roo	kville								1 Yes 2 No		
Mary r 28a-	Director	10e. Street and Num							Zip Code				10g. (	Citizen of What Co	puntry?		
s 23a c	필	1001 Roc	kville		: Apt 1 Was Deceder		J.S. 13. V		0852 edent of Hist	panic Orio	gin? (Sp	ecify Yes or	Chi		erican Indian, Black,		
death v	Funeral	1 X Never Marrie	d 2 M		Armed Forces				ecify Cuban,					White, etc.			
s after iral", o	<u>δ</u>	3 Widowed  15. Decedent's Edu		orced If Yes	Give Year		1		2 X No				Lin	Specify: Asi			
72 hour "natu	ompleted	Elementary/Secon			College (1-4 or		16a. Decede during		working life.				- 1	o. Kind of Busines: $^{\prime}$ isiting			
vithin 7	du				5+		Stud	ent					_ v	NIH	reliow		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Be Co	17. Father's Name (F		Last)									e, Maid	en Surname)			
212 212 2uld be I Ments mark ic even	TO B	Hanhua Wa 19a. Informant's Nan		hip (Type, F	Print )		19b. Maili	ng Addr		Yaoc and Num			lumber,	City or Town, Sta	te, Zip Code)		
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Ore,		20a. Method of Dispo	_	3 Re	emoval from S	tate	Place of Dispo crematory or o	ther pla	ce)			Date		c. Location - City o	,		
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Depr. Depr. Injuin		for f.	- au	_	M0095	6	7	Par	k Ave	, . G	'Thi aith	badeaı ersbuı	ı Mo	rtuary S MD 20877	ervice,p.a.		
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Examiner	ĺ	Immediate Cause (For condition resulting			ple Injuries		of):								Death		
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	nin	if any, leading to imm cause. Enter Underl (Disease or injury that	lying Cause	Due to	o (or as a cons	sequence o	of):										
nsit Are	Exal	events resulting in de			o (or as a cons	sequence o	of):										
Division of Vital Records, P.O. Box 68760, within 24 hours after death.  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	ical -	edical Examiner	ica	UNPENDED		d  ₹. ₽₩	ENDEP	nEU 1	0/15/10	7 171	Til Ma Ca						
760, icate be physic the bur		IF FEMALE: 23b. Was decedent p	regnant in th	230	c. ir yes, outco	me of preg	nancy	J, EN		_			12	23d. Date of delive			
Sox 6876 death certificate e attending phy I for use as the b	sician/N	past 12 months?		4	Live birth Pregnant a	t time of de	noth -	etal dea other <i>(</i> S		Ectopic	pregnar	icy		Month	Day Year		
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Division of Vital Records, P.O. Box 68760, tal or Attending Physician: The law requires that the death certificate be as fler death.  3a Director: After this certificate has been signed by the attending physiciled in by the funeral director, page 2 should be detached for use as the bun	<u>a</u>	Part II. Other signific	cant condit	ons contr	ibuting to dea	tn but not r	esuiting in the	unaeriy	ing cause gi	ven in Pa	irt I.				o the cause of death?		
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Vital Rec ysician: The l his certificate b director, page	Be C	25. Was case referre examiner?	ed to medica	-	1				26.Place		(Check or	nly one)					
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Division Hospital or Attent 24 hours after death Funeral Director:	Certification:	2 Accident 3 Suicide		tigation 2 d not be	8e. Place of I	njury - At h	l ome, farm, stre	et, facto	ory, office bu	ilding, etc	c. 2				tural Route Number, City		
Di spital hours a neral l	탕	4 Homicide 29a. Certifier					d / Highwa		_		-		of Roc	kville Pike , Roc			
To the Hospital within 24 hours To the Funeral completely filled	Medical	(Check only		miner:On th	e basis of exa	mination a								and manner as sta place, and due to t			
To To	ĕŀ	29b. Signature and ti	tle of certifie		nanner stated		<u>.</u>		29c. License	number			290	d. Date signed (Me	onth, Day, Year)		
96		hy	n	, V					O.C.M	1.E.			00	ctober 8, 2010	)		
		30. Name and addres			eted cause of all Examine		<sup>23a)</sup> Penn Stre	et Ra	ltimore M	MD 2124	01						
Str	ate	31. Date filed (Month)	Day, Year)		32. Registra			el, ba									
Regist		0.0	T 15	2010		ر س	M. 194	Sept.									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [ Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Jilliams Margaret :30AM 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgonery enter If Under 24 Hrs. If Unde Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Min. 378-28-5689 1□ M 2**□** F Months Days Hours 08 Director 0 Rhode Island 01/190 Usual Residence of Decedent 10d. Inside City Limits show 10a. State 10b. County 10c. City. Town or Location 7 is marked other than "natural", or Items 23a or 28a-f sho traumatic event, The Modical Exemination at the motified at Director MD 1 ☐ Yes 2 No Silver Spring Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 3126 Gracefield Road, BG 325 20904 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify þ Specify: White 3 Widowed 4 ☐ Divorced n and Mental Hygiene. Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Hygiene. Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Shober Kimber Mary Haines Ecroyd ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; if item 27 is any injury or other trau once. 3126 Gracefield Road, BG-325, Silver Spring, MD 20904 John S. Williams/Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Pages 1 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 16, Woodside Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2010 Ashton, Maryland 21. Signatur of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Coranal disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duc to (or as a consequence of) Examiner The law requires that the death certificate be executed Dialae Due to (or as a consequence of) burial physician Box 68760, Physician/Medical the, as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal deat
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy ь Month Day Year 5 ☐ Other (specify) the 1 ☐ Yes 2 Do o 9 Unknown 9 Unknown signed by the σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy certificate 1 ☐Yes 2 No of Vital I or Attending Physician: after death.
Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4M Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To neral Director: After the filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Division 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital c within 24 hours at To the Funeral C completely filled Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 8 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bel Pre P 31. Date filed (Month, Day, Year) Registrar's Signa park State 5 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar Certificate of Death		2010 Reg. No.	34441
Physici Medical Exam		Decedent's Name (First, Middle,Last)	2. Date of De Month October 2	ath	3. Time of Death
medical Exam	illei	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location		4c. County of Death	
		4103 8th Street Baltimore		None	
Funeral Director		215-82-8957 1 M 2 XF 46 Yrs. Months Days Ho	Jnder 24Hrs. 8. Date of Bours Min. 07/	Foreig	
any		Usual Residence of Decedent  10a. State			10d. Inside City Limits
ind show a	<u> </u>	MD Anne Arundel Glen Burnie			1 Yes 2 No
Maryla - 28a-f	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of Whai Coul	•
ith the 23a on	a Di	663 Rhone Court 21061  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic		United Stat	
leath w	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No		14. Race - Ameri `White, etc.	ican Indian, Black,
after d	by F	3 XWidowed 4 Divorced of Yes, Give Year 1 Yes 2 No spec		Specify: Wh	nite
2 hours "natur	ted	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  16a. Decedent's Usual Occupation (G during most of working life. DO N		16b. Kind of Business/I	ndustry
036 ithin 7, ne. r than Tedical	Completed	10 Waitress		Restaur	ant
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		17. Father's Name (First, Middle, Last)  2.1 Locate Depart 1.1	ther's Name (First, Middle,		
2127 uld be: Mental marke event	To Be	Albert Parrill  19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Name/Relationship)	Patricia All		Zip Code)
MD and 2 sho alth and 2 is 27 is aumatin		Carolyn Bomolis - sister 663 Rhone Court			
ore, es l and of Heal		20a. Method of Disposition  1 Burial 2 Xcremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	, Date	20c. Location - City or	Town, State
Baltimore, permit. Pages I an Department of Hea Important: If ites injury or other tr		4 Donation 5 Other Specify: Ardent Crematory	10/27/2010	Hanover,	MD
Balt permit. Depart Impor		71. Signature of Funery Strice Licensee 22. Name and Address of Fac	narry n. v	Witzke's Fam	
Physician		23á. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a failure. List only one cause on each line.	as cardiac or respiratory an	rest, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease a Cocaine and methadone intoxicat	ion		Death
		or condition resulting in death)  Due to (or as a consequence of):  b.			
	iner	if any, leading to immediate Due to (or as a consequence of):			
=	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	-		
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'60, cate be executed physician and ne burial - transi	Medical	IF FEMALE:  AMENDED	/5/10 TT	23d. Date of delivery	
687 ertifica ding pl		23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ecto	opic pregnancy	1	ay Year
Box 687 e death certific the attending p	Physician/	1  Yes 2 No 9 ✓ Unknown			
hat the ed by the letache	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in		obacco use contribute to t	
Division of Vital Records, P.O. ral or Attending Physician: The law requires that it is after death.  "I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacked.			1Yes		ably 4  Unknown
cords, law requir has been s	Completed		autor perfo	psy prior to comed? death?	ompletion of cause of
Vital Rec ysician: The l his certificate l		25. Was case referred to medical 26 Place of Dea	1 Yes	2 No 1 Yes	s 2 No
Vita hysicia this cer	o Be	examiner? 1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other <sub>4</sub>		Residence 6 🗸 Other:	Scene
n of ding Pl	in I	27. Manner of Death  28a. Date of Injury (Month, Day,Year)  28b. Time of Injury 28c. Injury at Wi (Month, Day,Year)  1 Natural 5 Pending  1 Pending  1 Natural 5 Pending  1 Natural 5 Pending  28c. Injury at Wi (Month, Day,Year)  28c. Injury at Wi (Month, Day,Year)  28c. Injury at Wi (Month, Day,Year)	ork? 28d. Describe	how injury occurred	
Sion Atten or death rector: by the	icati	Accident Investigation Ptd 10/24/10 Ftd 11:20 am' 168 20		Street and Number or Rur	al Route Number City
Div oital or ours afte	Certification:	3 Suicide 6 X Could not be determined (Specify) House	or Town, S Baltim	Street and Number or Rur state) $4103$ 8th ore, MD	St
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as if	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and each one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated.			
1 2 2 3	₹	29b. Signature and title of certifier 29c. License numb	er	29d. Date signed (Mon	
		O.C.M.E.		October 25, 2010	
3	ĺ	<ol> <li>Name and address of person who completed cause of death (Item 23a)</li> <li>Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, M</li> </ol>	D 21201		
	ate	31 Date filed (Month, Ray Veerley and 32 Registrar's Signature 4			
Regist	rar	001 27 2010 Leneus D. Jakes			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🚄 1. Decedent's Name (First, Middle, Last) 2. Date of Death October Day Year **Physician** William Lerov Warfield DOIDA 2010 13 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cambridge Dorchester General Norchester If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 ☑ M 2 □ F Months Days Hours Min 218-16-6802 86 June 11, **Director** 1924 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar", or items 23a or 28a-f show any injury or other traumatic event, Ite Medical Examinat must be indiffed at MD Dorchester Directo Cambridge 1 XYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 718 Hughlett Street 21613 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married white 1 ☐Yes 21 No Specify δ WWII 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) truck driver newspaper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Norman Warfield Leona Hubbard ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert L. Warfield 720 Hughlett St., Cambridge, MD son 21613 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cem 10/18/10 4 ☐ Donation 5 ☐ Other (Specify) Hurlock, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St. Cambridge, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** baamina disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Ecquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): and I-tran resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) the 9 Unknown 9 Unknown signed by the detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy certificate ha rector, page 2 2 No 1 ☐ Yes 2 No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 X ER/Outpatient 3 □ DOA 1 Inpatient Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural
2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 🗆 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: Af
completely filled in by the fu

Maryland 21215-0036

Baltimore,

X State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

lam

100 brample Registrar's Signature

29c. License number

Cambol age,

13,2010

Please Type or Bright in Black Indelible link. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month :109 Physician /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** The Johns Hopkins Hospital Baltimore City 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 🔀 M 2 🗆 F 188-12-5016 Yrs. 91 Director 25,1918  ${\it Dec.}$ Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 No Directo Examiner must be notified Boonsboro Maryland Washington 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ö 23a 8919 Crystal Falls Drive 21713 U.S.A. Funeral items 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No 1942 If Yes, Give Year or Dates: 1945 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2X Married 2 No 1942-Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 🔀 No Aq. Specify Specify: 3 Widowed 4 Divorced White 1945 'natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education the Medical (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) than College (1-4 or 5+) al Hygiene. Heavy Equipment Operator Cement Plant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental is marked Bertha E. Hose William D. Weaver မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; if item 27 is any injury or other trau (Wife) 8919 Crystal Falls Dr. Boonsboro, Maryland 21713 Mary Katherine Weaver 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State October Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 19, 2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MO1414 J.L. Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Maryland 21783 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to ( as a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last umonia Examine Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of): physician ar Division of Vital Records, P.O. Box 68760, Physician/Medical a ending 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 9 in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗌 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 🅦 Inpatient Other: 4 🗀 Nursing Home 2**X** No. 1 Tes 3 🗌 DOA 2 - ER/Outpatient ပ္ 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural Injury s after death. 1 Yes 2 🗌 No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

To the Funeral D

completely filled i Hospital 1 🗽 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie License number 29d. Date signed (Month, Day, Year) 40 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr.

Registrar

DHMH 17 Rev 1/2001

State

Geo Strey

31. Date filed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

MO

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Muriel Μ. Zais Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Western Maryland Health System Allegany Cumberland If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year) 919 reb 21 Months Hours Min. Maryland Director 220-07-6304 Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21502 United States 12711 Bowling Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: 3 XWidowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Clerk Retail Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked out any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Leonard Martha Wagner Brant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karyn J. Zais/daughter 9 Kestrel Lane Baltimore, Maryland 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 🙀 Cremation 3 🗆 Removal from State Final Journey Crematory 10/19/2010 4 Donation 5 Other (Specify) Woodbine, Maryland 21. Signature of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 M00957 manuta 23a. Part in Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shoot or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYOCARDIAC INFARCTION Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) sician and burial-transit Exam that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Live Birth 2 Fetal death in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Day Year Pregnant at time of death ed by the a detached f 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Hospital or Attending Physician: Be 26. Place of Death (Check only one) Other: 4 \( \triangle \) Nursing Home 5 \( \triangle \) Residence 6 \( \triangle \) Other (Specify, 2 🕅 No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 I 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After to completed filled in by the funera 1 🔀 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident
Suicide
Homicide Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 7 29b. Signature and title of certifier 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) MEMOX AVE WMB CR 21502 1A1

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Records,

Division of Vital

	10-08307 Karl Edward Ap	opleg	1- For State	oe or Print in ate of Maryla		idelible Ir artment of rtificate of		sure and	All Co Menta	<b>opies</b> al Hyg			20	10	34445
	Physic Medical Exam		Registrar  1. Decedent's Name (First, Midd  Karl Edwar			-	o dan				Date of De Month	Day	Year		3. Time of Death 0555 hrs
	)		4a. Facility Name (if not institution 329 Riverside Drive #	n, give street and nu			b. City, Tov Es <b>sex</b>	vn, or Lo	ocation of		October	40	c. County of Baltimore		
	Funera		Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under	1 Year	If Under	24Hrs.	8. Date of E			9 Birth	nplace (State or Foreign
1	Directo		216-66-2080	12 M 2 F	55	Yrs.	Months	Days	Hours	Min.	May3	,19	55	Cou	MD MD
1	id how any Eg.		Usual Residence of Decedent  10a. State 10b. County  MD Ba	ltimore	10c. City,	Town or Location	sex								10d. Inside City Limits  1 Yes 2 X No
1235	ne Maryland or 28a-f show fied at once.	Director	10e. Street and Number 329 Rivers	ide Driv			10f. Zip Co	ode 221		_			zen of Wha	t Coun	try?
17	death with the Maryland or items 23a or 28a-f shu nust be notified at once	Funeral D	11. Marital Status  1 Never Married 2 X M:	12. Was Dec	edent Ever in U.		Decedent s, specify (	of Hispa					USA 14. Race - White,		an Indian, Black,
	rs after d ural", or	by Fi	3 Widowed 4 Div	orced If Yes, Give Yea	r	116a. Decedent	Yes 2			ad of wor	k dono	I <sub>16b</sub> I	Specify: Kind of Busi		ite
	21215-0036  Uld be filed within 72 hours after death with the Maryland Mental Hygiene marked other than "natural", or items 23a or 28a-f sho cevent, the Medical Examiner must be notified at once.	Completed	Elementary/Secondary (0-12)	College (1		during mo	st of workin	g life. D	O NOT us			ŀ	Stack		
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medica	Be Co	17. Father's Name (First, Middle, John G. Ap	plegate					Ivá	a Ja	irst, Middle ne W	iser	man		
	ID 27 2 should and Me 27 is ma	ြိ	19a. Informant's Name/Relations Deborah A	, , , ,	/wife	19b. Mailing							•		Zip Code) 21221
	ore, IV		20a. Method of Disposition  1 Burial 2 Cremation		20b. F	Place of Disposit crematory or other	ion (Name	of ceme	tery,	C	)ate	20c. I	Location - C	ity or T	own, State
	altimo mit. Pag partment portant: ury or od	. 1	4 Donation 5 Other Sp 21. Si aftire of Funeral Service		B	ayview 22. Na	Crei			_					re MD lto. MD
	m ឱក្អ≣ Physician		23a. Part I. Enter the disease, or	complications that ca	the death.	Do not enter the	onne	lly	Fun						
	/Medical		failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line. a. <u>Cocain</u>	e And E	thanol :									Between Onset and Death
	- 130 Sept	L	Sequentially list conditions,	b	consequence of										
		Examiner	if any, teading to immediate cauce. Enter Underlying Cauce (Disease or injury that initiated events resulting in death) Last	C	consequence of									- 14	
`	executed an and al - transit	alEx	X UNPENDED	d											
	60, ate be en hysician	Medic	IF FEMALE:		23,27,2 outcome of pregr		cME,G	909,	11/3	0/20	10,WS		i. Date of de	elivery	
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/Medica	23b. Was decedent pregnant in th past 12 months?  1 Yes 2 No 9 Unk	I I TIME D	ant at time of dea		l death er (Specify,		Ectopic p	regnancy			Month	Da	ay Year
	b.O. E that the oned by the detached	by Ph	Part II. Other significant conditi	ons contributing to	death but not re	sulting in the un	derlying ca	use give	en in Part	1.	I		_	_	ne cause of death?
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	Reco The law ficate has	Completed									perf 1 Yes	ormed?	dea	ath? Yes	,
	/ital  ysician:  uis certi director	B Be	25. Was case referred to medical examiner?  1 ✓ Yes 2 No	Hospital: 1 1	npatient 2	ER/Outpatient	F	IOH	Death (C		one)	Reside	nce 6	Other:	Scene
	n of \ding Phy ding Phy After th	on: To	27. Manner of Death  1 Natural 5 Pend	28a. Date of Fnd 10	Day,Year)	28b. Time of Inj			at Work?		d. Describe		iry occurred		
	Division of Vital Records, P.O. tal or Attending Physician: The law requires that the starter death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Certification:	2 Accident Inves 3 Suicide 6 X Could determ	tigation 28e. Place	-31-10 of Injury - At ho Fnd at	me, farm, street	factory, of			JUI	or Town,	(Street a	nd Number 29 Ri aryla	ver	al Route Number, City side Drive
30	Division  To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical Ce	29a Cortifier	ysician; To the best	of my knowledg f examination ar	e, death occurre	d at the tim	ne, date inion, de	and place	, and du	e to the cau	use(s) an	d manner a	s stated	i. cause(s)
7		Me	29b. Signature and title of certifier					cense n					Date signed ober 31,	•	h, Day,Year)
	OOME		30. Name and address of verson Mary G. Ripper MD.	who completed cause Deputy Chief M			l Penn Str	eet. E	Baltimor	e, MD	21201	12-12-1			
*	S Regis	tate trar	31. Date filed (Month, Day Year)	-	gistrar's Signatur										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month JOHN AVRAMIDIS **OCTOBER** Medical 2010 5:25 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death STELLA MARIS HOSPICE BALTIMORE TIMONIUM Social Security Number If Under 1 Year 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🕅 M 2 🗆 F Months Days Hours Min. (Month, Day, Year) MAY 5, 1921 Country) Director Yrs 214-56-8098 89 TURKEY Usual Residence of Decedent 28a-f show 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD BALTIMORE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 625 RAPPOLLA 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. and Mental Hygiene. is marked other than "natural", or 1 Never Married 2 Married þ 1 Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates WHITE 1 Yes 2 No Specify. Specify: 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 12TH PRINT PRIVATE CO other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ SERA FIN AVRAMIDIS HELEN RIZOPOULOU 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau MICHAEL AVRAMIDIS/SON 625 RAPPOLLA ST. BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1  $\boxtimes$  Burial 2  $\square$  Cremation 3  $\square$  Removal from State 4 Donation 5 Other (Specify) 11/01/2010 ORTHODOX CEM WOODLAWN, MD any inj once. 21. Signature of Juner 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 2007-09 EASTERN AVE., BALTIMORE, MD 23a. Part 1. Enter the disease or complications that caused shock, or heart failure. Use only one cause on each line. complications that caused the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) BLADDER CANCER Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or de a consequence or, Examir use as the burlal-transit and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 the attending IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day be detached Unknown 9 Unknown P.0. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 2 No 3 Probably 4 Unknown 1 🔲 Yes peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has page 2 autops, performed: 2 No Division of Vital director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 🗌 Yes 2 X No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 I 4 ☐ Nursing Home 5 ☐ Residence 6 Other (Specify) HOSPICE funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After 28d. Describe how injury occurred X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature ar 29d. Date signed (Month, Day, Year) 12010 of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar JACKIE JONES,

31. Date filed (Month, Day, Year)

5:25

2010

OCTOBER

JOHN AVRAMIDIS

ORIGINAL

2300 DULANEY VALLEY RD.

TIMONIUM,

			Please Type or Prin	aryland / [	Department	of H	lealth ar	e All Copies ad Mental Hy		ible.	
					Certificate	e of	Death		Reg. No.		34448
			1. Decedent's Name (First, Middle, Last)					2. Date of D Month		Year	3. Time of Death
	Physici /Medic		Edward Michael Alt					Octobe	r 29	2010	21:00
	Examir		4e Fecility Neme (If not institution, give street end number)				4b. City, Town	, or Location of Dee	th 4c. Coun	y of Deeth	ו
*			1805 Palo Circle				Baltim	ore	Balt	imore	
	Funeral	-	5. Sociel Security Number 6. Sex 7. Ag	e (In yrs. lest bir	thday) If Under Months		If Under 24		rth ev. Year).	9. Birth	polace (State or Foreign
	Director		214-21-0974   ¹\(\overline{\text{\tin}\text{\tex{\tex	27	Yrs.	20,0		May 29	,1983	Mary	Land
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	er de	E I	11. Maritel Status  12. Was Decedent Armed Forces?		If Yes, spec	ent of F ify Cub	an, Mexican, F	? (Specify Yes or No Puerto Rican, etc.)		ack, White	
N	s aft	by F	1 Never Merried 2 Married 1 Yes 2 N 1 Yes, Give Year or Detes:	NO	1 ☐ Yes 2	₩ No	Specify:		Spec	ify: W	hite
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9	be filed withintal Hygiene. d other than event, the M		17. Father's Neme (First, Middle, Last)		TVEL		18. Mother's	Name (First, Middle			100
O	id be ental ked o	To Be	Robert Wesley Alt, Jr.				Debora	ah Ann Di	etz		
2	d 2 should be th and Menta 7 la marked traumatic ev	-	19a. Informant's Name/Relationship (Type, Print)	19b	. Meiling Address	(Street	and Number	or Rurel Route Numi	per, City or Tow	n, Stete, Z	ip Code)
Ξ	od 27 la		Robert Wesley Alt, Jr. / Fath	ner 180	5 Palo C	irc	le Bal	timore,Ma	ryland 2	21227	
ē,	f Hee fem offhe	-	20a. Method of Disposition	20b. Place of	Disposition (Namery, crematory or of	e of		Date	20c. Location	_	Town, State
	Pages net of nt: If its iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify)	Atlant	ic Crema	tor	y,LLC.	11/1/20	0 Glen	Burn	ie,Maryland
paitimo	F. E. E. E.		21. Six—ure of Juneral Service Licensee	632	22. Name and	d Addre	ss of Facility	AMBROSE FI	JNERAL I	HOME.	INC.
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	Physician		shock, or heart failure. List only one cause on each lin	ne.			1			1	Interval Between Onset and Death
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	law las b	힏						_		d	of death?
	The ate h page	S						*	Yas 200No	1. 1	I∐Yes 2⊠No
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	fter t	ë	27. Manner of Deeth 1 □ Natural 5 □ Pending 28e. Date of Inju	y Year) 28b. 1		Bc. Injui		/ · ·	how injury occ	urred ( (	
2	eath. or: A	cat	2 Accident investigation 2 2 2 3 3 Scuicide 6 Could not be 389 Place of Initial		OPM		Yes 3.2No	3416.6	eby		31415
	r Ari frar d irect	Certification:	4 Homicide determined 28e. Place of Injury building, etc.	ry - At home, fa c. <i>(Specify)</i>	rm, street, factory,	, office		28f. Location City or Te	own, Stete)	313	Irel Rous Number,
נ	rei Dallied i	ပ္			vn t			Hathon		751	227
	To the Hospital or Attending Physician: The law requires that the death certificate be as within 24 hours aftar death.  To the Euneral Director: After this cartificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the buria	edical	29a. Certifier 1☐ Certifying Physician: To the best of (Check only one) Medical Examine: On the basis of and manner sta	examination an	, death occurred a d/or investigation,	ir the tir	me, date and p ppinion, death	place, and due to the occurred at the time	rcause(s) and r , date and place	nanner as a, and due	to the cause(s)
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)		4	20 Name and eddress of person who completed cause of	eth (Item 23e) (	(Type, Print)	-,	41	(le, Mc	211	0 ~	
	-01	2	31. Date filed (Month, Day, Year) 32. Registre	er's Signature	E HILL	1,4	(Inont)	115/1000	210	17	
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DHMH 16 Rev 6/95

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** October 2010 11:55 P M Deorae /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Elkton Rehab E1kton Cecil 5. Social Security Number If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Year) 1 2 M 2 □ F 57746 1604 Director 10/06 Georgia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event; the Medical Examiner must be notified at aprese. 10b. Count 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director MU IKton 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21921 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc 1 Never Married 2 Married 1 ☐Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. 3 ☐ Widowed 4 ☐ Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Unk College (1-4or 5+) Elementary/Secondary (0-12) janitorial 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George C. Beall Arlene Brindy ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louise Hindle - sister-in-law 527 Old Home Road; Baltimore, Maryland 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 ☐ Buriat 2 ☐ Cremation 3 ☐ Removal from State 4⊠ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronald S. Wade, Director 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed 01/0 and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) the 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ icate has been sig ; page 2 should b 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy performe certificate 1 □ Yes : After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of De th 28b. Time of 28c. 28d. Describe how injury occurred 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 1 □ Yes 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 20060756 29d. Date signed (Month, Day, Year) 30. Name and address of person who c plet d cause of death (Item 23a) (Type, Print) w main

DHMH 17 Rev 1/2001

State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Armin Menzel Bruning October 2010 16 5:45 Α 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Somerford House Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, March 7) Months Days Hours Min. March 7, 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Year) 1927 11☑ M 2 □ F Maryland Yrs 214-22-9833 83 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Frederick 1 ☐Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 816 Ivy Way; Apt 1A 21701 USA 12. Was Decedent Ever in U.S. Armed Forces? 1★JYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 28 Married 1 ☐ Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry unk (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Armin Joseph Bruning Olga Marie Menzel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julia T. Bruning - wife 816 Ivy Way Apt 1A; Frederick, MD 21701 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify)

Physician /Medical Examiner

Physician

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the "Modical Expraising must be notified at once.

Baltimore, Maryland 21215-0036

/Medical

Director

Funeral

ð

Completed

Be

2

10a. State

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit sician and burial-trans attending p signed by the a

Division of Vital Records, P.O. Box 68760,

	21. Sign ture funeral Space Licer On 3	Wade Sirector 22. N. 6.	ame and Address of Facility St 55 W. Baltimore			, MD 21201
	23a. Part 1. Enter the disease or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the death. Do not enter to one cause on each line.  a	ne mode of dying, such as cardia	ac or respiratory arrest,	72	Approximate Interval Between Onset and Death
completed by Physician/Medical Examiner	Sequentially list conditions, if any leading to him additions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):				
Iysiciaii/iwea	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □ Unknown		topic pregnancy ner (specify)		23d. Date of del Month	livery Day Year
ca by r	Part II. Other significant conditions of	ontributing to death but not resulting in the under		23e. Did tobacco		the cause of death?
and more				24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of 2  No
3	25. Was case referred to medical examiner?			ath (Check only one)		
	1 163 2 2 10	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	☐ DOA Other: 4 A Nursing I	Home 5 ☐ Residence	6 □Other (Spec	cify)
	27. Manner of Death 1  Natural 5  Pending 2  Accident investigation		28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inj	ury occurred	
	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office	28f. Location (Street: City or Town, Sta	and Number or Ru te)	ural Route Number,
	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exam	ysician: To the best of my knowledge, death oc liner: On the basis of examination and/or invest and manner stated.	curred at the time, date and place gation, in my opinion, death occ	e, and due to the cause urred at the time, date a	(s) and manner as nd place, and due	s stated. to the cause(s)
	29b. Signature and title of certifier	6. Convey, und	29c. License number D20395	29d. E	Date signed (Month	75, 2010

State Registrar 31. Date file

Johns Hopkins Comm. 45 Thomas Johnson Ave Frederick ,MD 21702

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William H. Convey

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 34451 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** October 20 You Diana Eleanor Barry 12:00 P M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2831 Basehores Mill Road Taneytown Carrol1 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth Jan 28, **Funeral** 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign Days Hours 1 □ M 2 🖾 F Min. 450-18-1853 91 T919 Kansas Director Yrs Usual Residence of Decedent filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Evantines must be routified at once. 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll Taneytown 1 ☐ Yes 2 ☐ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 2831 Basehores Mill Road Funeral 21787 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White \$ 1 ☐ Yes 2 No Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade com 16b. Kind of Business/Industry Un. grade completed) Elementary/Secondary (0-12) College (1-4or 5+) legal secretary 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Don Cameron Estes Eleanor Lavenia McDowell ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanor C. Bragin - daughter 3100 N. Leisure World Blvd; Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signatur Funeral Prvice Licensee Republic S. W 22. Name and Address of Facility State Anatomy Board Director in 655 W. Baltimore Street; Baltimore, MD 21201 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Autorine /Medical Due to v r as a consequence of): Examiner Sequentially list conditions, Examiner If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to for asia conseque (ce of) and burial-trar P.O. Box 68760, attending physician for use as the buria Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month signed by the a 5 ☐ Other (specify) Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No page 2 should Completed 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an autopsy performe certificate 1 ☐ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home Certification: To 1 Yes 2 No this 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director; After thi completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of Division 28d. Describe how injury occurred Natural Accident 5 Pending investigation 2 □No 1 ☐ Yes 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only the ပ္ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 26 30. Name and address of person who completed

State Registrar Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - State Registrar 34452 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ RUBY MAY BERGER NOVEMBER 20**°**0 1:16 A<sub>M</sub> Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE PERRY HALL 16 FARWELL CI If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days JUNE 9, 1927 1 □ M 2 👿 F Hours Min. 83 Country) MICHIGAN 367-24-9910 Director Yrs. Usual Residence of Decedent death with the Maryland aţ 10a, State 10c. City, Town or Location Director 10d. Inside City Limits must be notified 28a-f PERRY HALL BALTIMORE MD 1 Yes 2 X No 10g, Citizen of What Country? 5 10e. Street and Number 10f. Zip Code Funeral 23a 21236 16 FARWELL CT 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 'natural", or iter dical Examiner Armed Force 14. Race - American Indian, þ 1 Never Married 2 Married Black, White Baltimore, Maryland 21215-0036 Yes 2 🔀 No WHITE If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 ☐ Divorced Completed permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) ENGINEER MANAGER 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) TELEPHONE COMPANY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ LUKE CRAYCRAFT HAZEL CROSSET 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1427 HALLOWELL LN NEW WINDSOR, MD 21/76 1427 HALLOWELL LN JOHN BERGER-SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗀 Removal from State OWINGS MILLS, MD 4 ☐ Donation 5 ☐ Other (Specify) 11/12/10 GARRISON FOREST Signature of Furieral Service Licenses 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC BALTIMORE, MD 21206 6415 BELAIR RD 23a. Part 1. Enter the disease shock, or heart faiture. I or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Ph sician/ Onset and Death Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): cause, Enter Underlying the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): physician Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Hospital or Attending Physician: The law requires that the death of thours after death. in the past 12 months?

1 Yes 2 No
9 Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown Month Day Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Xes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown After this certificate has been 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of performed death? Yes 2 N Vita completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗆 Yes 2 X No ၉ Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify Division of 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide within 24 hours after deat To the Funeral Director: Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rastelos Bel Aur Md 21014 22. Regis Registrar

DHMH 17 Rev 7/2009

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Berg

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day November 2 Year **Physician** worden 2010 /Medical 4c. County of Death Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Daltmore romwel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5-16-1949 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months 1 M XX S.C. 219-56-4658 Director 61 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County "natural", or Items 23a or 28a-f show dical Examiner must be notified at 1 Yes 2 □ No MD Director na Baltimore Pages 1 and 2 should be filed within 72 hours after death with the Innent of Health and Mental Hygiene.
ant: If Item 27 is anarked other than "natural", or Items 23a or 28auny or other traumatic event, the Medical Examiner must be notifi 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1400 E. Coldspring Lane 21239 USA Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2€No Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade <u>Maintenance</u> State of MD 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Willie B. Curbeam ٩ Emily Hill 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5815 Loch Raven Blvd Balto,, MD 21239 Denise Curbeam-Sister Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State Important: If any Injury or once, 4 Donation 5 D9ther (Specify) 11-8-2010 Garden of Faith Rosedale, MD 22. Name and Address of Facility 21. Signature of Fundal Service Lice March East F/H 1101 Ε. North Avenue Balto, MD 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician erobrovasc *leans* /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 □ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate ha 2 HNo 25. Was case referred medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To 1 Inpatient this 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: / 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after the Funeral D 1 🗲 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 RW 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marsheles Dr. Elkvidge, Md. 2017 new State Registrar

DHMH 17 Rev 1/2001

10-07938	
Eugene Carson	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ugene Carsor	1	State of Maryland / Departmen	it of Health and Mental H e of Death		2010	34454
Physic	ian/	Registrar	- Or Death	Reg 2. Date of Death	. No.	3. Time of Death
ledical Exam				Month October 16	Day Year , 2010	0701 hrs
		Facility Name (if not institution, give street and number)     Union Memorial Hospital	4b. City, Town, or Location of Deat Baltimore	h	4c. County of Death	
Funeral		5. Social Security Number un 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24Hr	s. 8. Date of Birth		thplace (State or Unit
Director		1×M 2 F 62	Yrs. Months Days Hours Mir	July 5,	1948 Foreig	gn untry)
kus	1	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or I	ocation			10d. Inside City Limits
* .	_	MD Baltimo				1 X Yes 2 No
Aaryland 28a-f show 1.at once.	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Cou	ntry?
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important of Health is marked other than "natural", or items 23a or 28a-f she injury or other traumatite event, the Medical Examiner must be notified at once	Ö	2327 N. Charles Street	21218		USA	
th with tems 2 st be n	uneral	11. Marital Status Unk 12. Was Decedent Ever in U.S. 13 Armed Forces? Unk 14. Marital Status Unk 15. Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto</li> </ol>		14. Race - Ameri White, etc.	can Indian, Black,
ter des ", or i	교	1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	Yes 2X No specify:		Specify: Whi	te
ours af atural samin	d by	15. Decedent's Education (Specity only highest grade completed) 16a. Dec	edent's Usual Occupation (Give kind of		16b. Kind of Business/	ndustry UNK
6 n 72 h an "n ical Es	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	ng most of working life. DO NOT use ret	ired)		
-003 within giene. ther the	H O	unk unk 17. Father's Name (First, Middle, Last) unk	18 Mother's Name	e (First Middle Ma	iden Surname) unk	
215. oe filec ntal Hy ked of	Be C	dik		( not, made, ma	naon oumano, cellic	
21 hould then and Mer is mar	2		ailing Address (Street and Number or			, Zip Code)
MC and 2 stath an em 27 raums			11 Penn Street; Ba		MD 21201 20c. Location - City or	Town State
Ore ges 1 a t of He t fits		1 Burial 2 Cremation 3 Removal from State crematory	or other place)	Date /	EGG. EGGGIIGHT GRY GI	rown, otate
Iltim nit. Pa artmen ortani		4   Donation 5   Other Specify: in State	22. Name and Address of Facility St	ate Anato	my Board	
E Dep De Liniu		Rolland S. Made, Director	655 W. Baltimore			MD 21201
Physician /Medical		23a. Part I. Enter the disease, or comprications that caused the death. Do not er failure. List only one cause on each line.	nter the mode of dying, such as cardiac of	or respiratory arrest	t, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)  a Hypertensive Atherosclerotic C  Due to (or as a consequence of):	ardiovascular Disease			Death
		Sequentially list conditions, b				
	iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause				
pa gr	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
68760, certificate be executed nding physician and use as the burial - transit	<u>e</u>	d. UNPENDED AMENDED				
68760, certificate be ex nding physician se as the burial		IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth			23d. Date of delivery	
Sox 6876  death certificate e attending phy for use as the	cian	past 12 months?    1   Live birth   2   2   4   Pregnant at time of death   5	Fetal death 3 Ectopic pregna Other (Specify)	ancy	Month E	ay Year
<b>—</b> = ± ≥	Physician/	1 Yes 2 No 9 Unknown 9 Unknown				
ires that the signed by	þ	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.		acco use contribute to	
ords, w require s been si	Completed			24a. Was an		topsy findings available
D a a c	dwc			autopsy performe	ed? death?	ompletion of cause of
tal Recision: The certificate ector, page	Be Co	25. Was case referred to medical	26.Place of Death (Check			2 2 110
Vita Physici r this c	To B	examiner? 1 Yes 2 No  Hospital: 1 Inpatient 2 FR/Outpa			esidence 6 Other	:
ion of tending I eath. tor: Afte the funer		27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month, Day,Year)  28b. Time	e of Injury 28c, Injury at Work?  1 Yes 2 No	28d. Describe how	w injury occurred	
ivision At after d Direct	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm,	street, factory, office building, etc.	28f. Location (Stre or Town, Stat		ral Route Number, City
Hospital 24 hours Funeral tely fillec		4 Homicide determined (Specify)  29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death of	accurred at the time, date and place, and	due to the eques(s	a) and manner on state	
To the Hospital within 24 hours To the Funeral completely fille	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or invession and manner stated.				
F×FS	Me	29b. Signature and title of certifier	29c. License number		9d. Date signed (Mor.	
		(auni)	O.C.M.E.		October 17, 2010	· · · · · · · · · · · · · · · · · · ·
		Name and address of person who completed cause of death (Item 23a)     Zabiullah Ali, M.D. Assistant Medical Examiner 111 F	Penn Street, Baltimore, MD 21	201		
S	tate	31. Date filed (Month, Day, Year)	Red			

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 01:25 AM 2010 Raymond John Cooper Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** AGNES BALTIMORE HOSPITAL If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8 Date of Birth 6 Sev 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Days Min 1 X M 2 □ F Ma<u>ryland</u> Yrs Director 212-10-2886 97 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits 72 hours after death with the Maryland Director 1 Tyes 2 X No Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1903 Logwind 21228 USA Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 X Yes 2 No If Yes, Give 1 Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: White Year or Dates. 1943-46 3 X Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Health and Mental Hygiene. tem 27 is marked other than " College (1-4 or 5+) Elementary/Seconday (0-12) Salesman Office Equipment permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ٥ John Cooper Lillian Swift 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela Herrick 1907 Logwind Road; Catonsville, MD 21228 Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 11/10/2010 Owings Mills, Maryland arrison Forest 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Enheral Service Lice 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Sepsis Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death signed by the at d be detached for 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Records, Congestive heart Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hypertension autopsy page 2 rmed? 1 ☐ Yes 2 ☑ No COPER, 26. Place of Death (Check only one) Division of Vital 25. Was case referred to medical director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 V No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending 2 No thours after death.

uneral Director: Af
ed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined. 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi 2 U Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) MEKONEN, M.D. D64312 EYASU October 31, 2010 Exasu Mekonen, M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVENUE BALTIMORE 21229 CATON Registrar's Signat 31. Date filed (Month, Day, Year State Registrar

DHMH 17 Rev 7/2009

RAYMOND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #2 Per Phy G909 11/04/10 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 10-30-2010 1. Decedent's Name (First, Middle, Last) Day Physician/ Month AMONT Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Northwest Randalistown hospital Hmore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, 56 Months Days Hours Min. Country) 217-64-5865 Director 9-18-1954 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director Randallstown 1 ☐ Yes 2 🕅 No Baltimore MD 10e. Street and Number 10f. Zip Code 0 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be Funeral 3519 Cabot Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. African-American 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumation. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Systems Administrator Nothrop Grunnen Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Herman M. Cahill Pauline Wooten 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3519 Cabot Road, Randallstown, MD 21133 Elizabeth Darcy Cahill/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Donation 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Owings Mills, Md 11-10-2010 Forest Veterans 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. Signature of Funeral Service Licensee 9200 Liberty Road, Randallstown, MD 21133 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SCV Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Dav 5 Other (specify) Pregnant at time of death been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 6 1 ☐ Yes 2. ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed 2 1 No 1 Yes 21 24 hours after death.

Funeral Director: After this certificeted filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10-30-10. D0062610 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) randallstown MD 2113 1 old court ron (zaib) 31. Date filed (Month, Day, Year) NOV 0 4 2010 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amedn #1, per MD g908 11/4/10 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Gertrude Carona 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 7:45 AM 01 2010 112 113 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death LEVINDALE HEBREW HOME BALTIMORE N/AIf Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) 1 M 2 F 93 10/24/1917 MD 214-22-1025 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1√Yes 2 No N/A BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2434 W. BELVEDERE AVENUE 21215 USA 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. WHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SALESPERSON RETAIL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) BARSHOP KOLKER HARRY YETTA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) RHODA MARX/NIECE 1190 W. NORTHERN PARKWAY, #619, BALTIMORE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place BETH YEHUDA ANSHE KURLAND CEMETERY Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐Removal from State 11/03/2010 BALTIMORE, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ignature of Funeral Service L SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 complications that caused the only one cause on each line. Approximate Interval Between Onset and Death eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease or shock, or heart failure. List Immediate Cause (Final COLONAL disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury) Due to (or as a consequence of): 23d. Date of delivery Year Month Day o use contribute to the cause of death? 2 No 3 □ Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 6 ☐Other (Specify) iury occurred

**Physician** /Medical **Examiner** Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, in 24 hours after deam.
the Funeral Director: After the fulled in by the fu

Physician

Examiner

**Funeral** 

**Director** 

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Director

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Pages 1 and 2 should be filed within 72 hours after anent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

/Medical

Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):	
ical Exa	resulting in death) Last	Due to (or as a consequence of):	
by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	
Completed by Pl	Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco
	25. Was case referred to medical	26 Place of Des	ath (Check only one)
To Be	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing H	
	27. Manner of Death  1 Natural 5 □ Pending 2 □ Accident investigati	28a. Date of Injury (Month, Day Year)  28b. Time of Injury  M  28c. Injury at Work?  1 □ Yes 2 □ No	28d. Describe how in
Certification:	3 Suicide 6 Could not 4 Homicide determine		28f. Location (Street City or Town, Sta
O			

1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

MYSICIAN 10064533

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LCVINDALE CTERIATRIC BALTIMORE MD 21215

2434 W. BELVEDERE AVENUE BABATUNDE

31. Date filed (Month, State Registrar

Medical

32. Registrar's Signature

within 2 To the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 EMMA CARROLL GIBBS DIGGS November 10:18 AM Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death **Examiner** 4c. County of Death PICKERSGILL RETIREMENT COMMUNITY Towson Baltimore County 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min. 1 □ M 2 🔽 F Jan 24, Year 913 218-80-6588 Kentucky 97 Director Usual Residence of Decedent or items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must hamoristical and injury or other traumatic event, the Medical Examinar must hamoristical and injury or other traumatic event. **Funeral Director** 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore County 1 ☐ Yes 2X No Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 615 Chestnut Avenue 21204 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No
If Yes, Give by I 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: White 3 X Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Residence Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Harry Drake Gibbs Camille Hopper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David S. Diggs 9701 Mossy Stone Court, Vienna, Virginia 22182 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Green Mount Crematory 11/3/2010 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signative of Function S. Lawson MINCHELL WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician e rebrovasc UVAR disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, list cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Day to for early consequency of To the Hospital or Attending Physician: The law requires that the death certificate be exect Due to (or as a consequence of): resulting in death) Last physician Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Day Year 1 Yes 2 g Unknown the a 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death2 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 s autopsy performed Yes 2 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 🗆 No ည 1  $\square$  Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After the completed filled in by the funeral Certificate: 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b, Signature and title of certifie

Registrar
DHMH 17 Rev 7/2009

State

30. Name

31. Date filed (Month, Day, Year)

NOV 0 4 2010

and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ALLACE DEPUTS 7 1602 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BATIMONE CIT N/AUNNOUSTRY OF MACYLAND MODILAL LETTER Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 🔀 M 2 🗆 F Min West Virginia **Director** 235-15-7824 44 Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director Charles La Plata MD 1 ☐ Yes 2X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ral", or items 23a or Examiner must be I Funeral 1406 Leicester Drive 20646 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📈 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 XNever Married 2 Married ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🕅 No Specify: Specify: "natural" 3 Widowed 4 Divorced Completed White the Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Computers Radio Broadcasting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ DePriest Wallace J. Uphene Μ. Holliday 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health item 27 Uphene M. DePriest, mother Box 80 Smoot. WV 24977 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o ó 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory, Inc. 11/02/10 Baltimore. 21. Signature of Funeral Service Licensee George 22. Name and Address of Facility Cremation Society of MD, Inc. MacNabb Seo 299 Frederick Road BAltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final. Physician/ BEAIN HEENIATION disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** ty Mo CERHAL-S Sequentially list conditions if any, leading to immediate cause. Enter Underlying Examir and I-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury ACQUICO IMMUNE DOFICIONA SYNOROME that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 performed? Yes 2 No certificate 2 No ☐ Yes 1 Yes 25. Was case referred to medical director 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 M Natural 5 Pending work? within 24 hours after death.

To the Funeral Director: A completed filled in by the formal completed filled in by the formal completed filled in by the formal completed filled in by the formal completed filled in by the formal completed filled in by the formal completed filled in by the formal completed filled in by the formal completed filled in the formal completed filled filled in the formal completed filled 2 🗆 No ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 1 🖊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number NPI: 119 403 79 60 ind title of certifier 29b. Signaty 29d. Date signed (Month, Day, Year) November 1, 2010 DEA: AU UI 76 435K1007 CESTER MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 SGRENEST, BATTIME ZITE KETTUR WIVESITY OF MADYLAND 31. Date filed (Month, Day, Year) State 04 Registrar

DHMH 17 Rev 7/2009

10-08273 Dorothy Derosa Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 31.1

protriy L	reiosa		1- For State Registrar	tate of Maryland	•	artment of He artificate of De		itai Hygiene	Reg. No.	2010	34406
	hysici		Decedent's Name (First, Mid.					2. Date of D Month	eath Day	Year	3. Time of Death
edical	∟xam	ıner	Dorothy DeRos  4a. Facility Name (if not instituting the content of the content o		<u> </u>	4b. C	ity, Town, or Location	October	29, 20	10 . County of Death	1540 hrs
			Howard County Gene				olumbia	or Bourn		Howard	
	ineral		5. Social Security Number	6. Sex 7. Ag	e (In yrs.		Under 1 Year If Und		Birth(MM/	(DD/YYYY) 9. Bir Foreig	
Dir	ector		216-32-6163	1 M 2 X F	76	Yrs.	Diluis Days Hour	s Min. 09/2	9/193	34 Co	<sup>untry)</sup> Marylan
	any		Usual Residence of Decedent  10a. State 10b. County	,	10c. City	y, Town or Location					10d. Inside City Limits
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Maryla	28a-f show d at once.	Director	10e. Street and Number		•	10f	Zip Code		10g. Citi	zen of What Cour	ntry?
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eath w	items ust be	Funeral		Married 12. Was Decedent	,		ecify Cuban, Mexican	gin? ( Specify Yes or I , Puerto Rican, etc.)	NO-	White, etc.	can Indian, Black,
after d	al", or	by Ft	3 X Widowed 4 Di	vorced If Yes, Give Year or Dates:	X No	1 Yes	2 No specify.		1	Specify: W	hite
hours	'natur Exami	ted k	15. Decedent's Education (Special Control of	ecify only highest grade con			ual Occupation (Give working life. DO NOT		16b. k	Kind of Business/I	ndustry
36 hin 72	than tedical	Completed	Elementary/Secondary (0-12)	) College (1-4 or	D+)	Bar	ık Teller			Banki	ng
5-00 led wit	Hygren other the M	Con	17. Father's Name (First, Middle	e, Last)		<u> </u>		's Name (First, Middle		Surname)	
121 Id be fi	lental narked event,	o Be	George Koesto  19a. Informant's Name/Relation:			10h Mailine Add	(Standard Mar	Mari nber or Rural Route N		naffer	7: 0 ()
AD 2 2 shou	27 is n matic	ř	Debbie Ostro		er)			enue, Balt			
1 and	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shoi injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition  1 XBurial 2 Crematio			Place of Disposition ( crematory or other place	Name of cemetery,	Date		Location - City or	
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<b>3alt</b> i	mport njury		21. Signature of Funeral Service	Licensee			and Address of Facility	Hubbard	Fune	eral Hom	e, Inc.
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/Me	dical		failure. List only one cause Immediate Cause (Final disease	Managalan Internet	During	Left Nephrector	y Procedure				Between Onset and Death
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<b>60,</b> ate be exe	hysician and e burial - transit	Medical	UNPENDED	AMENDED							
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Div Hospital or	neral I	Cert	4 Homicide dete	rmined (Specify) Hos	pital			5755 Cedar	Lane, Co	olumbia , MD	
	the Fun	Medical		hysician: To the best of my miner:On the basis of exam							
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12		ı	30. Name and address of person			*	Donn Street D-	ltimoro MD 2424	31		
1,0	91	ate	Patricia Aronica-Polla 31. Date filed (Month, Day, Year)	lee p. i.i.	0:		renn Street, Ba	Itimore, MD 2120	J T		
F	ىد Regist		MAY 0 4 2010	Mary &	1	arke					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** C. ELLYSON ODETTE OSDO AM 10 2010 /Medical 4a. Facilify Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner GLEN MEDDOWS Baltimore Glen Arm Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 26, 1928 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🖾 F Months Days Hours Yrs. France 219-28-3243 82 Director Usual Residence of Decedent 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Expedience must be notified at Director 1 ☐ Yes 2 🖾 No MD Baltimore Glen Arm 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11630 Glen Arm Road 21057 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11, Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after or and Mental Hygiene.

is marked other than "natural", or iter 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chemist Warren Lambert Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filt.
Department of Health and Mental H.
Important: If Item 27 is marked oth
any Injury or other traumatic eveni Be Paulette Greie Paul Boor ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 171 Granger Road, Unit 158; Medina, Ohio 44256 STeve L. Ellyson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State 10/29/2010 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, Atlantic Crematory 22. Name and Address of Facility Sterling Ashton Schwab Witzke 21. Signature of Funeral Service Licensee Funeral Home of Catonsville, 1630 Edmondson Avenue; Caton 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) robable RLL **Physician** /Medical Due to (or as a consequence of): Examiner month Sequentially list conditions, if any, leading to infine nate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 DNo Month Day Year Pregnant at time of death 5 ☐ Other (specify) o 9 Unknown 9 Unknown ٦. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Onknown 24a. Was an autopsy performed? 1 ☐ Yes 2 ♣ No 24b. Were autopsy findings available prior to completion of cause of death? has e 2 s Physician: The page 2 HNo 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? e Hospital or Attending P 24 hours after death. e Funeral Director: After t letely filled in by the funera 28d. Describe how injury occurred Division Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funeral D completely filled i 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the Pwithin 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie R079.544 10-27-2010

Registrar

DHMH 17 Rev 1/2001

State

30. Name and address of person

31. Date filed (Month, Day,

SPE 4105 TOWSM, MD 21204

no completed cause of death (Item 23a) (Type, Print)

Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Searcy James Ewell, Sr. october 2010 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charles Plater Medical Lû If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) March 30, 1928 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1√2 M 2 ☐ F Missouri 496-38-2907 Director 82 Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2xxNo Director MD Prince Georges Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Important; if item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be i 10315 Grandhaven Ave 20772 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2(X) No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2KXNo Specify Specify: Black Completed by 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) School Teacher/Band Director MD School System 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard Manley Ewell Ella Mae Walton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 trnent of Health McIntosh K. Ewell Son 10315 Grandhaven Ave, Upper Marlboro, MD 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State Roselawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Nov 6, 2010 Little Rock, Arkansas 22. Name and Address of Facility Fink Funeral Home, P.A. 21. Signature of Funeral Service L Gregory Fink 426 Crain Hwy S., Glen Burnie, MD 21061 M01148 23a. Part1. Enter the disease, or shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Final Multisystem Organ Failure Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any leading of mediaticause. Enter Underlying Cause (Disease or injury a Dandida Bucheren nokus Exami burial-transi resulting in death) Last certificate be exec Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atte I be detached for in the past 12 months? 4□Pregnant at time of death
9□Unknown Month Year Day 5 Other (specify) P.0. 2 🗆 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 9 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 TYes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Medical and manner stated. 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) compl ded cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Charlene 31. Date filed (Month, Day, Year)

NOV 04 2010

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 2010 Nov. 3:25 P M Richard Martin Faulstich Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Center Towson 7. Age (In yrs. last birthday) If Under Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Maryland (Month, Day <sup>Year]</sup>1946 Months Hours 1 Dt M 2 🗆 F 212-48-6974 Director 64 Apr. Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director Columbia 1 Yes 2 No MD Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21045 USA 7328 Mossy Brink Ct. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 X Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Pilot Aviation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eleanor Franz Joseph Faulstich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7328 Mossy Brink Ct., Columbia, MD 21045 Dianne K. Faulstich, Wife 20b. Place of Disposition (Name of cemetery crematory or other place)
Metro Crematory, Inc. 20a. Method of Disposition Date 20c. Location - City or Town, State Department of = 6 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Important: If any injury or 11/04/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Alvson Taylor 22. Name and Address of Facility Cremation Society of MD 299 Frederick Rd., Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician, disease or condition resulting in death) RR PARC Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjuty that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPERTENSAN Completed 1 Yes 2 No 3 Probably 4 Junknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗌 Yes 2 No Yes completed filled in by the funeral director. To Be 25. Was case referred to nedical 26. Place of Death (Check only one) examiner? HOSPICE Other: 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 Accident
3 Suicide
4 Homicide 2 No Investigation Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 29c. License number **D46360** 

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year

04 2010

HAPLES STREET BALTIMURS MO 2/204

nd address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November D 7:30 P. M Edward Lee Fink 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Genesis Eldercare Hammonds Lane Anne Arundel Baltimore 8. Date of Birth (Month, Day, Year) 10/25/1937 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Hours 1 X M 2 1 West Virginia 73 Director 219 26 7668 Usual Residence of Decedent or 28a-f shov 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d, Inside City Limits other traumatic event, the Medical Examiner must be notified at Director Anne Arundel **Baltimore** Maryland 1 🗌 Yes 2 ื No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 516 Church Street U.S.A. 21225 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. à 1 Never Married 2 Married Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 2 No Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 3rd College (1-4 or 5+) Disabled N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ (not available) Ethel Fink 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Langrehr / Friend 516 Church Street Baltimore, Maryland 21225 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite 5 injury Glen Haven Mem. Park 4 Donation 5 Other (Specify) 11/04/2010 Glen Burnie, Maryland 21. Signature of Juneral Service II 22. Name and Address of Facility Gonce Funeral Service, P.A. Baltimore, Maryland 21225 4001 Ritchie Highway 23a. Part 1. Enter the disease, or complications that cause he death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause or ch line. Immediate Cause (Final Onset and Death Physiciani disease or condition VERNOWIA Medical resulting in death) as a consequence of) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a nonsequence of) attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Year Day signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen s 24b. Were autopsy findings available prior to completion of cause of has autopsy death? within 24 hours after death.

To the Funeral Director, After this certificate I completed filled in by the funeral director, page 2 🗌 No 1 Yes ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other 1 🗌 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Naturai 5 Pending 1 Yes Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and 29d. Date signed (Month, Day, Year) **2106**(

Registrar DHMH 17 Rev 7/2009

State

28.

dress of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sig

10-07608 Alice Faidley Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Alice Faidley		State of 1-For State Registrar	Maryland / Depart Certif	ment of ficate of		Mental F		201 Reg. No.	0 34406
Physicia Medical Examin	n/	Decedent's Name (First, Middle,Last)	<u></u>				2. Date of De Month	ath Day Year	3. Time of Death 2140 hrs
)	101	Alice Faidley  4a. Facility Name (if not institution, give str	reet and number)	4	b. City, Town, or Lo	cation of Deat	October :	3, 2010 4c. County of I	
		Mercy Hospital			Baltimore				
Funeral Director	ĺ	5. Social Security Number unk 6. Sex	7. Age (In yrs. last	birthday)	If Under 1 Year Months Days	If Under 24Hr Hours Mir	_		). Birthplace (State or UNK oreign
Director	ļ		2XF 61	Yrs.		1100.0	bct 9,	1948	Country)
any	ł	Usual Residence of Decedent  10a. State 10b. County	10c. City, To	wn or Location	on	-			10d. Inside City Limits
Maryland 28a-f show any 1 at once.	5	MD	Balt	imore					1 X Yes 2 No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 524 N. Charles S	treet; Apt 151	.0	10f. Zip Code 21201			10g. Citizen of What USA	Country?
ms 23s			. Was Decedent Ever in U.S. Armed Forces? UNK		Decedent of Hispan				merican Indian, Black,
ter death	Funeral	1 Never Married 2 Married 1 1 1 1 2 Midowed 4 Divorced If Y	Yes 2 No		s, specify Cuban, M Yes 2 No s		Rican, etc.)	White, e	
ours af	함	15. Decedent's Education (Specify only h	Dates:	Sa. Decedent	s Usual Occupation	(Give kind of		1146b. Kind of Busin	
6 n 72 hc an "nu ical Ex	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	during mo	st of working life. Do	O NOT use ret	ired)		
within giene.	Ē.	unk 17. Father's Name (First, Middle, Last) u	unk		1191	Mother's Name	/Eiret Middle	Maiden Surname) U	nk
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	Be C	Tr. Factor's Hame (First, Middle, East,)	iik		10.1	WIOLINET S INAITH	s (First, Middle,	Maiden Surname)	
21 hould hould hould Mer is mar	힏	19a. Informant's Name/Relationship (Type,	Print )	19b. Mailing	Address (Street ar	nd Number or	Rural Route Nu	mber, City or Town, S	State, Zip Code)
MD and 2 sho salth and em 27 is raumati	-	O.C.M.E.  20a. Method of Disposition	20h Plac		enn Stree		timore,	MD 21201	at as Town State
Baltimore, cernit. Pages 1 a Department of He Important: If ite Important: If ite Injury or other to		1 Burial 2 Cremation 3 I	Removal from State crer	natory or other		ery,	Date	20c. Eocation - Ci	y or Town, State
Itimit. Partiment ortant	-	4 Donation 5 Other Specify: 11	n state	22 Na	me and Address of	Facility C + c	to Anat	omy Board	-
Depression in just		21. Signature of Funeral Se V. e Licensee Romand S. W	de/Director					-	re, MD 21201
Physician	Ī	23a. Part I. Enter the disease, or complicat failure. List only one cause on each !i	ons that caused the death. Do						Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a. or condition resulting in death)	Cocaine Intox	icatio	n				Death
		b	to (or as a consequence of);						
	ner	Sequentially list conditions,	to (or as a consequence of):						
	Examiner	(Disperse or folius that Wittelest	to (or as a consequence of):						
50, te be executed ysician and burial - transit	ᇹ	d						·	
O, be ex sician surial	Medical		MENDED 23a,27,2		er me g90 	9 11–1	0-10 vt		
Box 68760, a death certificate be the attending physici ed for use as the burn	Ž	ob. was decedent pregnant in the	3c. If yes, outcome of pregnant		I death 3	Ectopic pregna	incy	23d. Date of del Month	very Day Year
lox 6876 eath certificate attending phy for use as the	Physician/N	past 12 months?  1 Yes 2 ✓ No 9 Unknown 10	Pregnant at time of death		er (Specify)				
J. B.	ᇍ		Unknown tributing to death but not result	tina in the un	derlying cause giver	n in Part I	23e. Did to	obacco use contribut	e to the cause of death?
P.C es that igned	اھ				,,				Probably 4 🗸 Unknown
ords, w requir	Completed						24a. Was		e autopsy findings available to completion of cause of
eco he law ate has	틹						perfo	rmed? deat	
of Vital Records, ag Physician: The law required the third this certificate has been a moral director, page 2 should	Be	25. Was case referred to medical examiner?				Death (Check			
Physic rr this cral dire	의	1 ✓ Yes 2 No	i inputerit 2 V Liv						ther:
nding Phy nding Phy th. : After the	<u></u>	27. Manner of Death  1 Natural 5 Pending	(Month, Day, Year)	b. Time of Inji	40.	_	_	how injury occurred	
S 4 5 5 5	ertification:	2 Accident Investigation	<b>fd</b> 10-3-10   <b>f</b> e 28e. Place of Injury - At home	d 8:40 , farm, street,	Pm		unknow 28f. Location (\$	Street and Number of	Rural Route Number, City Charles St.
Divisor of property of the pro		4 Homicide determined	(Specify) house				Apt. Town 5	TO Baltin	Charles St.
			To the best of my knowledge, of						
To the within To the comple	2 L	2	the basis of examination and/o manner stated.	n investigatio	n, in my opinion, dea		t the time, date	and place, and due t	
		francos of the	1		O.C.M.E			October 4, 20	
	+	30. Name and address of person who comp	Ideted cause of death (Item 23a	1)					
			sistant Medical Examir	ner 111	Penn Street, B	altimore, M	ID 21201		
Sta	te	31. Date filed (Month, Day Yoar)	32. Registra s Signature	Kal		1.7			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month // Physician/ 09 N N 8:15 am 0/ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 7. Age (In yrs. last birthday) 54 vrs 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min (Month, Day, Year) av 7 1956 Country) Maryland 216-68-7656 Director May Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shoi 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel 1 Yes 24 No Arnold 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 305 College Pkwy United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 XDivorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Retail Weis Markets Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ Richard Becker Lillian Humphrey permit, Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Scott William Fick -1165 Priestford Rd., Street, MD 21154 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) Nov. 4,2010 Glen Burnie, MD 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause in each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Medical resulting in death) **Examiner** Sequentially list conditions, it any local gits in reading cause. Enter Underlying Examine Due to (or as a nonsequence of) Cause (Disease or iinjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Month the Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy eral Director: After this certificate if filled in by the funeral director, page 1 Yes 2 No ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No Other: မ 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatur 50725 o completed cause of death (Item 23a) (Type, Print

Registrar

DHMH 17 Rev 7/2009

State

10-08355	
Herbert Gore	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

lerbert Gore		State of Maryland / De	epartment of <i>Certificate of</i>		d Mental H		201 eg. No.	0 34468
Physiciai Medical Examin	n/	1. Decedent's Name (First, Middle,Last) Herbert Gore, Jr.				2. Date of Deal Month November	Day Year	3. Time of Death 1515 hrs
		4a. Facility Name (if not institution, give street and number) 603 Denison Street	4	4b. City, Town, or I Baltimore	Location of Death		4c. County of	Death N/A
Funeral Director		5. Social Security Number 212-58-1739 6. Sex 17. Age (In 1984)	yrs. last birthday) 7 Yrs	If Under 1 Year Months Days	If Under 24Hrs Hours Min			9. Birthplace (State or Foreign Country) SC
and show any <u>nce.</u>		Usual Residence of Decedent   10a. State   10b. County   10c.	City, Town or Locati Baltimo					10d. Inside City Limits 1 XYes 2 No
th the Marylan 23a or 28a-f s notified at on	Director	10e. Street and Number 603 Denison St.		10f. Zip Code 2122	29	11	0g. Citizen of What USA	-
er death wi	by Funeral	11. Marital Status 1 Never Marned 2 Married Armed Forces? 1 Yes 2 1 1 Yes 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	No If Y	i. 13. Was Decedent of Hispanic Origin? (Speif Yes, specify Cuban, Mexican, Puerto F  1 Yes 2 No specify:  16a. Decedent's Usual Occupation (Give kind of wo			White, Afri Afri Specify: A	can merican
5-0036 led within 72 hours tygiene. other than "natus the Medical Exam	Completed	15. Decedent's Education (Specify only highest grade complete  Elementary/Secondary (0-12)  College (1-4 or 5+)  2	during m	rs Usual Occupations of working life.			McCorm	
21215-0036 Build be filed within 7 Mental Hygiene marked other than to event, the Medica	8	17. Father's Name (First, Middle, Last) Herbert Gore, Sr.	Lao: Mari		Ruby A	lston	Maiden Surname)	0
ore, MD 2 es 1 and 2 shoul of Health and M If item 27 is mher traumatic e	-[	19a. Informant's Name/Relationship (Type, Print )  Ruby Gore/Mother  20a. Method of Disposition		Denison	St.,Ba			State, Zip Code)
Baltimore, permit. Pages I as Department of He Important: If ite injury or other tr		1 X Buriat 2 Cremation 3 Removal from State	crematory or oth Arbutus	mer place) Mem Pk	11/		Arbutus	·
Physician Physician	4	21. Signary of Funeral Price Licensee	- P14	го вета.	II Ru, E	dill., I.	Close F. ID 21206 est, shock, or heart	Approximate Interval
/Medical		failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Seizure di  Due to (or as a consequer	sorder					Between Onset and Death
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	nce of):					
nnd cuted	I Examiner	(Disease or injury that initiated events resulting in death) Last    C.  Due to (or as a consequer d.	ice of):					
50, te be exe iysician a	ledical	IF FEMALE: 23c. If yes, outcome of		g909 11/	30/10 TT	,	23d. Date of de	alivery
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial circus:	Physician/M	3b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  1 Unknown	2 Fel	tal death 3 [ ner (Specify)	Ectopic pregna	ancy	Month	Day Year
i, P.O. B res that the d signed by the lbe detached	6	Part II. Other significant conditions contributing to death but  Chronic alcohol and dru	-	nderlying cause gi	iven in Part I.			rte to the cause of death?  Probably 4 Unknown
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safer death.  The law requires that the safer death.  The this certificate has been signed by led in by the funeral director, page 2 should be deated.	Completed					1 Yes	rmed? dea	ere autopsy findings available or to completion of cause of ath?  Yes 2 No
Vital Rec ysician: The his certificate director, page	o Be	25. Was case referred to medical examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2	2 ER/Outpatient		of Death (Check Other Nursin		Residence 6	Other: Scene
ion of vending Phreat.	⊢†	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation	28b. Time of li		y at Work? es 2 No	28d Describe h	how injury occurred	
Division At the property of th	Certification:	3 Suicide 6 Could not be determined (Specify)	At home, farm, stree	et, factory, office bu	uilding, etc.	28f. Location (S or Town, S		or Rural Route Number, City
To the Hos within 24 h To the Fun	Medical	29a. Certifier 1 ☐ Certifying Physician: To the best of my kno (check only one) 2 ✓ Medical Examiner: On the basis of examinat and manner stated.		ion, in my opinion,	death occurred a		and place, and due	to the cause(s)
	2	296 Signature and title of coaffiler Seek 3.	0,50	29c. License O.C.M			November 2,	(Month, Day, Year) 2010
Oxpend		30. Name and address of person who completed cause of death Victor Weedn MD JD Assistant Medical Exa	aminer 111 P	enn Street, B	altimore, MD	21201		
Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature 32. 33. 33. 33. 33. 33. 33. 33. 33. 33.	gnature					

amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Alfonso Grant Physician/ Month Dav Year <del>ALFON 20</del> 50 PM Medical 2010 OCTOBER 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GREATER BALTIMORE MEDICAL CENTER BALTIMORE TOWSON 5. Social Security Number If Under 1 Year 7. Age (In vrs. last birthday) 8. Date of Birth
(Month, Day, Year)
7-15-1940 If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1**X** M 2 □ F Months Days 217-38-5669 Hours Director 10.4 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location ortant: If Item 27 is marked other than "natural", or Items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at with the Maryland 10d. Inside City Limits Director Ba Ito 1 Yes 2 No owson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21286 nsom USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. δ 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates. 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry should be filed within 72 ho n and Mental Hygiene. 7 is marked other than "na (Give kind of work done during most of working life. DO NOT use retired) Balto 200 Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade interance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or contract. ည **Alfonso** Grant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christina Gibson - Nièce Road 10WSDn, MD 21286 500 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 10-18-2010 Balto, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee March East F/H 22. Name and Address of Facility MD 21202 1101 Ε. North Avenue Balto, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pneumonia Physician/ disease or condition Medical resulting in death) Examiner Mesothelioma Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to lor as a consumuence of Hospital or Attending Physician: The law requires that the death certificate be executed and -trans resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown 2 No 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by disorder 1 Tes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 2 🗆 No Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred 1 ANatural 5 Pending injury Accident Suicide 1 ☐ Yes 2 ☐ No Investigation within 24 hours after death

To the Funeral Director; A 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number D0056156 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21204 6565 North Charles Street Baltimore, M. Caccamese mo land SUZANUL Registrar's Signa State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Marvell Ghoston Sr. 08:00 AM DCTOBER 31 /Medical 2016 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner n/a Agnes Hospital Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 MC 5. Social Security Number 6. Sex 1 XM 2 ☐ F 8. Date of Birth (Month Day 3-8-1948 7. Age (In vrs. last birthday) Funeral Year) Months Days Hours 378-46-4122 Yrs MS Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10h County 10d. Inside City Limits show ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, Ite Medical Examination must be notified at Director MD 1 ☐ Yes 2 ☑ No Baltimore Windsor Mill 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3629 Rockdale Terrace 21244 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∆Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: African-American þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Utility Service Repair Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic ev Clyde W. Ghoston Frankie Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenonda D. Ghoston/Wife 3629 Rockdale Terrace, Windsor Mill, MD 21244 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State Garrison Forest Veterans 11-10-2010 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wile Funeral Home P.A. of Palto. Co. 21. Signature Funeral Service, Licensee 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Extending the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastockers a consequence of the condition resulting in death) Approximate Interval Between Onset and Death **Physician** Months /Medical Due to (or as a consequence of): Examiner AIDS Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical phys the L attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) been signed by the should be detached 1 ☐ Yes 2 ☐ No Ö 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy certificate 1 ☐ Yes 2 XNo 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) (Specify) 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ After thi 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred the Hospital or Attending 5 ☐ Pending investigation Division 1 Natural 2 Accident within 24 hours arren ...... To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number Medical Resident P23613 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) halise. Baltimore. 900 Caton Ave, Nath 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 6:50 A M **Physician** November 2010 Margaret A. Hamill /Medical 4a. Facility Name (If not institution, give street and number) Butinore 4c. County of Death City Town, or Location of Death Examiner Agnes Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🂢 F Months Days Hours Yrs Director 80 217-26-8202 Feb 8, 1930 Maryland Usual Residence of Decedent th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Director N/A Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5509 Mattfeldt Avenue Funeral 21209 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. White Specify: Completed by 3 Widowed Will Divorced 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Accounting Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carroll Edwin Caverly Sr. Grace Elizabeth Staines 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any Injury or other trau once. 1023 Stormont Circle Halethorpe, MD 21227 Joan E. Chandler, Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 11/02/10 Baltimore, Maryland 21. Signature of Funeral Service Licens Thomas Gregor 22. Name and Address of Facility Cremation Society Of Maryland, Inc. Morran 299 Frederick Road Baltimore, Maryland 21228 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sepsis **Physician** /Medical Due to or as a consequence of Examiner months renal Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) ears that the death certificate be executed stage wem a burial-tran physician s the burial Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day Division of Vital Records, P.O. After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Mongaret 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 ☐ No 1 ☐ Yes 2. ☐ NO 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural 5 Pending Hamili 8:40 AM investigation 10, 29,9010 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (specify)

Assisted uvry 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, state)
101 N Becchand Ave, Catory 16 M determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) w.D November, 2, 2010 list 2406 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Catona  $\omega_{\mathcal{D}}$ 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 04 2010 Registrar

DHMH 17 Rev 1/2001

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		State of Maryland / Department of Health and Mental Hygiene  State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Reg. No. 2010 34473
Physici		1. Decedent's Name (First, Middle, Last)  Jerry F. Hempfield  2. Date of Death  North  Day  Year  10-53 AM
Medi Exami		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death Union Memorial Hosp.  4c. County of Death N/A
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 8 / 28 / 54 MD
yland f show ed at	ctor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
h the Mar 3a or 28a 5e notifi	al Director	10e. Street and Number 1608 N. Warwick Ave 10f. Zip Code 21216 10g. Citizen of What Country? USA
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black White, etc.
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d within 7/3 lygiene.	Be Com	Elementary/Seconday (0-12) College (1-4 or 5+) life. DO NOT use retired)  Laborer Construction
should be filed within 7 and Mental Hygiene. 7 is marked other than raumatic event, the M	To B	17. Father's Name (First, Middle, Last)  Michael Hempfield  18. Mother's Name (First, Middle, Maiden Surname)  Lillian Hempfield
and 2 should Health and M tem 27 is mar		19a. Informant's Name/Relationship (Type, Print)  Hattie Morgan/Sister  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  1608 N. Warwick Av, Balt., MD 21216
permit. Page 1 s Department of H Important: If ite any injury or ot once,		20a. Method of Disposition    Date   Date   Community
permit Depar Impor any in		21. Signature of Fundal Service Censee 22. Name and Address of Facility Hari P. Close F. Svs, PA 5126 Belair Rd, Balt., MD 21206-5105
n <sub>nysician/</sub>		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition
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the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.  the Funeral Director: After this certificate has been signed by the attending physician and mpleted filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Live Birth 2   Fetal death 3   Ectopic pregnancy   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   Month   Day   Year   9   Unknown   9   Unk
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he Hospi in 24 hou he Funer ipleted fill	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
To t To t		29b. Signature and title of certifier  AT 2 4 38 9 46  29d. Date signed (Month, Day, Year)  11 / 03 / 2010
2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  BINETOU FALL, MB UNION MEMORIAL HOSPITAL, 201 E. University PXWY  BALTIMOREX MD 21218
Sta Registi		31. Date filed (Month, Day, Year)  32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician HOLCOMB MARGARET VIRGINIA october 30 2010 /Medical County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number, **Examiner** tor 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 71918 1 □ M 2 🕱 F Months Days Min 92 MARYLAND 107097 214-03-0201 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examment in ust be instituted at 1 □Yes 2 No CHURCHVILLE Director MD HARFORD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 310 WINDSOR COURT 21028 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕱 No Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify. Specify: WHITE \$ 3 → Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) HOMEMAKER OWN HOME 6 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be TOMS UNK. UNK. MYERS ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) WINDSOR COURT CHURCHVILLE, MD 21028 KEITHLEY/ ROLAND Date 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State BELAIR MEMORIAL 11/02/10 BEL AIR, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Se ice Licensee 21237 1211 CHESACO AVE BALTIMORE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** LYPER /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for I Month Year in the past 12 men Pregnant at time of death 5 Other (specify) □Yes After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 3 Probably 4 Unknown 1 ☐ Yes Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 1 ☐Yes 2 ☐ No 0 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 NO 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending PI within 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exampler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier pleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who co

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiere 1 19/2010dhb Certificate of Death 1 - For State Registrar Amend 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 1:20AM Nancy Ρ. Horton OCTOBER 27 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore 4c. County of Death Examiner SOOS. ST. AGNES HOSPITAL GITON If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 M 2 F 214 38 9079 Yrs 80 Director July 16,1930 N.C. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item-27 is marked other than "natural", or other traumatic event than "natural". 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore 1 X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3504 Howard Pk.Ave. 21207 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) Nurse's Asstant Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Walton Janie Askew 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janie Watson (daughter) 3504 Howard Pk. Ave. Balto, Md. 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cem. Nov. 3,2010 Baltimore, Md. Signature of Funeral Service Licensee Calvin B. Scruggs Funeral Home wags 1412 E. Preston St. Balto, Md. 23a. Part 1. Enter the disease, or complications that caused the distance of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** Acute myocurdial Infaction disease or condition resulting in death) days / hours /Medical Due to (or as a consequence of): Examiner months UROSEPSIS. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dua to for sele consecutions on The law requires that the death certificate be executed years HIN signed by the attending physician and use as the burial-trai Due to (or as a consequence of): Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify). 1 ☐Yes 2 ☐No Ö 9 Unknown 9 Unknown ٦ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u>ک</u> 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy this certificate 1 □Yes Vital 2 ANO 1 ☐ Yes 2 No ours after death.

eral Director: After this certific filled in by the funeral director. or Attending Physiclan: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To ð 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P25924. PGY1. 10/27/2010. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bishow Chandra 900 Shuce the. Ave MD 21229. Certon 2. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G909 11/09/10 JH
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 2, 2010 **Physician** Hood Margaret L. 11:30 a M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore 7914 Chipper Road Windsor Mill If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 213 – 36 – 1272 Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕅 F 72 Maryland 10/25/1938 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 → No Md. Director Baltimore Windsor Mill with the 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 21244 USA 7914 Chipper Road Funeral death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Maryland 21215-0036 Specify: White þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 9 Glass Service Secretary traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marion Ethel Brown Otto Louis Fischbach 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trau John W. Hood, Jr. / Husband 7914 Chipper Road, Winsor Mill, Maryland 21244 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 10/5/2010 Meadowridge Mem. Pk. Elkridge, Maryland 4 Donation 5 ☐ Other (Specify) 21. Signatura of Funeral Service Licensee <sup>22. Name and Address of Facility</sup> Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Squamous cancer of Immediate Cause (Final disease or condition resulting in death) **Physician** vieta /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner anding physician and use as the burial-transi The law requires that the death certificate be execute Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown ō Day 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an 1☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death Check onl one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No ို this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death after death, I Director; After to d in by the funera Certification: Injury 5 Pending investigation 1 Natural 1 □ Yes 2 □ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide within 24 hours af

To the Funeral D

completely filled in 🛌 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 5/8587 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

State

Baltimore MD 21229

and address of person who completed cause of death (Item 23a) (Type, Print)

10-08029 Helen Hagan Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

mend #95tate of Maryland Department of the althor and Wenter Hyglene 3/14/2011 JH

Helen Hagan		1- For State Registrar		te <del>bf</del> Mailyla		arthfiem o rtificate o		nd*NMer	ntar Hyg		14/20] Reg. No.	20 I	0 3447				
Physicia Medical Examin	er	1. Decedent's Nam Helen Ha	igan							Date of De Month October	Day 19, 2010	Year	3. Time of Death 0955 hrs				
7		4a. Facility Name (i	f not institution, ce Street Ap		mber)		4b. City, Town, o Baltimore	r Location			!	ounty of Dea					
Funeral Director		5. Social Security N		Sex  M 2XF	7. Age (In yrs. I	last birthday) $51$ Yrs	If Under 1 Ye Months Da		2.01	8. Date of B April		_ Fore	Birthplace (State or <del>unk</del> eign Country) <b>Marylan</b>				
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the Maryland or 28a-f sh	by Funeral Dire	10e. Street and Nu		treet; Aj			10f. Zip Code 21230	)			10g. Citizen USA						
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21215-0 und be filed v Mental Hygiv marked othe	Re	17. Father's Name  Earl  19a. Informant's Na	Hammons		1.	19b. Mailin	g Address (Stre	Е	lelens	irst, Middle,  John al Route Nu	ns	·					
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.			Cremation  Other Spec	3 Removal fro	om State 20b. I	Place of Dispos crematory or ot	lame and Addres	emetery, s of Facilit	y Stat	e Ana	20c. Loca	ation - City o	or Town, State				
Physician /Medical	1	23a. Part I. Enter th	e disease, of co	mplications that ca	used the death.	. Do not enter t	he mode of dying	, such as o	cardiac or re	espiratory an	rest, shock,	or heart	Approximate Interval Between Onset and Death				
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Box 68760, e death certificate be ethe attending physicia ed for use as the burial	ΣΙ.	IF FEMALE: (3b. Was decedent past 12 months	pregnant in the	19a- 23c. If yes, o 1 Live bi 4 Pregna	rth ant at time of de	2 Fe	-f, per tal death 3 her (Specify)		E, G90		30/10 23d. Da Mor	ate of delive	Day Year				
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/ital F	a P	25. Was case referr examiner? 1 ✓ Yes		Hospital: 1	patient 2	ER/Outpatient		of Death	(Check onl		Residence	6 Oth	er: Scene				
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Divis  To the Hospital or A within 24 hours after completely filled in b	egicai	one) 2 🗸	Medical Examir	ician: To the best ner:On the basis of and manner sta	f examination ar		ion, in my opinior	n, death oc			and place,	and due to t	he cause(s)				
		29b Signature and	11	o completed con-	of death / Man	239)	29c. Licens					er 20, 201	onth, Day, Year)				
		Zabiullah Ali	, M.D. As	sistant Medica	I Examiner	111 Pen	n Street, Balt	timore, I	MD 2120	1							
Stat	e :	31. Date filed (Monti	Pay A That	?. Reg	istrar's Signatu	e barr											

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #9,11,12,15,16a&b,17,18,19a&b&22 Per FH G909 11/03/10 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month FRANKLIN HAMILTON OCTOBER 0900 A M 2010 /Medical 4a. Facility Name (If not institution, give street and number) MEDICAL 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE JOHNS HOPKINS BAYNEW CENTER If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nov 8, 1941 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1X M 2 □ F 217-38-4435 68 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 'natural", or Items 23a or 28a-f shov dical Examiner must be notified at MD **Baltimore** Yes 2 No Director 10f. Zip Code 21224 10g. Citizen of What Country? USA 10e. Street and Number 411 Southeast Avenue Funeral 14. Race - American Indian. 11. Marital Status unk Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 📆 ivorced Completed 16a. Decedent's Usual Occupation the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) than College (1-4or 5+) Cook 12 should be filed whand Mental Hygie 7 is marked other to Hospitality 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk Be permit. Pages 1 and 2 should be Department of Health and Menta. Important: If item 27 is marked 1 any injury or other traumatic evone. james Becraft Lillian Hamilton 2 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7021 Contey St. Balto, MD 21224
4940 Eastern Avenue; Baltimore, Maryland 21 19a Informant's Name/Relationship (Jype. Print) Nancy Mulcare/sister Bayview Medical Center Maryland 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ remation 3 ☐ Removal from State 4 ☐ Donation. 5 ☑ Other (Specify) 1n State Chesapeake Crematory 10/29/2010 Beltsville,MD 22. Name and Address of Facility State And Long Pourd Cremation and Uneral Alternatures 055 W. Baltimore Street, Baltimore, 8717 Green Pastures DR. Balto, MD 21286 Funeral Service Licen <del>MD 2120</del>1 enn Approximate Interval Between Onset and Death 3 DAYS Park Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PNEUMONIA **Physician** /Medical Due to (or as a consequence of): S 45ARS Examiner LUNG CANCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transi Due to (or as a consequence of): Box 68760. nding physician þe Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached fi P.0. 1 ☐ Yes 2 ☐ No. 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?/ Yes 2.2 No 1☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ this 27. Manner of Death 1. Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After Injury 5 ☐ Pending investigation dea h. 1 ☐ Yes 2 ☐ No Hospital or Attend 24 hours after deah. Funeral Director 2 Accident completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours 29a. Certifier (Check only one) To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES-600 ~ M ML 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 EASTERN AVE. BALTIMORE, MD 21224 TANYAPORN WANSOM, MD 31. Date filed (M 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Baltimore Randallstown Northwest Hospital 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 5. Social Security Number Age (In yrs. last birthday) Funeral Days Month, Day, -14-1934 Year) Hours Min. 1 M 2 X F 76 Yrs Director 212-34-4454 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ones. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🛣No Baltimore Pikesville MD 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 4607 Horizon Circle. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black, White, etc. Armed Forces?
1 ☐ Yes 2 🔀 No 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: Specify: African-American If Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Damestic Homenaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Flora Walker William Newton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4607 Horizon Circle, Apt. 101, Pikesville, MD 21208 Fred Holmes/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1√ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Veterans | 11-12-2010 Owings Mills, MD 22. Name and Address of Facility Wylie Funeral Home P.A. of Baltimore Co. Signatur f Funeral Service Licensee 9200 Liberty Road, Randallstown, MD 21133 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) e to√or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): and I-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy Month in the past 12 months?

1 Yes 2 No Day ☐ Pregnant a Pregnant at time of death 5 Other (specify) n signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown cate has been sig ; page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has performed 1 Yes 2 No 26. Place of Death (Check only one) director, 25. Was case referred to medica Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 FR/Outpatient 3 IDOA 2 No within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 □ 29b. Signature and title of certifier

DHMH 17 Rev 7/2009

State Registrar Name and address of person

31. Date filed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print)

. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ HERSCHMAN HALLIS 105/ AM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Houmo GENERAL HUSTINA COLUMBIA HOWARD COUNTY 6. Sex If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country)

NTX **Funeral** 1 ₹ M 2 ☐ F Days Hours Min. 04/122/1947 NY **Director** 309-52-7917 63 Usual Residence of Decedent 10c. City, Town or Location items 23a or 28a-f sho ner must be notified at 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 X No MD HOWARD LAUREL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20723 7712 TWIN OAKS WAY USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 10 ð 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: "natural" Completed 3 Divorced 4 Divorced Year or Dates WHITE the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 l
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "n:
any injury or other traumatic event, the Medic (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ELECTRICAL ENGINEER **AEROSPACE** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HERSCHMAN ROITZAID LILLIAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANDREA HERSCHMAN/WIFE 7712 TWIN OAKS WAY, LAUREL, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, XBurial 2 ☐ Cremation 3 ☐ Removal from State COLUMBIA MEMORIAL PK | 11/3/2010 CLARKSVILLE, MD 4 Donation 5 Other (Specify) . Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., May Le 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ HYPO BYCEMIA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner DIABETES MEDICADOM - INSULN. Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of) D. BETES the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year ☐ Yes 2.☐ ☐ Unknown ate has been signed by t page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENSIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 Natural 28d. Describe how injury occurred 5 Pending 1 Yes 2 No Investigation 6 Could not be 2 Accident
3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title **)**29c. License number 29d. Date signed (Month, Day, Year) 050538 30 2010 30. Name and address of person who completed cause of death (Hem/23a) (Type, Print) . Mi ha 31. Date filed (Month, Day, Year) Registrar's Signatur Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #9 Per FH G90911/04/10 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** ONES 0 1600 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BROADWAY 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 M 20 Hours Months Days Min Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. Cify, Town or Location 10a. State 10b. County 10d. Inside City Limits items 23a or 28a-f show ner must be notified at 1 Pres 2 No Director TIMORE 10e. Street and Number 10g. Citizen of What Country? 21213 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Examiner 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No 3 Widowed 4 □ Divorced þ Completed Kind of Business/Industry Injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) StodiAr 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 -EWIS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EDUR9 Md. 21206 20a. Methed of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) Date 1 ☑ Burial 2 ☐ Cremation 3 ☐Remov 4 □ Donation 5 □ Other (Specify) 6 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications of shock, or heart failure. List only one cause Approximate Interval Between Onset and Death at caused the death. Do not enter the mode of dying, such as cardiac or respiratory Immediate Cause (Final disease or condition resulting in death) **Physician** 20 years Coroner /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably ♣☐ Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No hasi certificate 250 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 1 ☐ Yes > No P To the Funeral Director: After this completely filled in by the funeral dir 4 Nursing Home 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Scrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES-UDO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Centur 5+ 601 min 2. Registrar's Signature 31. Date filed (Month, Day, Year) State 4 2010 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jendersee 2010 3:15 P M Shirley Marie October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cockeysville Baltimore 10701 Cardington Way Apt. 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs 8. Date of Birth 5. Social Security Number 7. Age (In vrs. last birthday) Funeral Min. Aug. 1, Year) 926 1 □ M 2 🗓 Hours Director 84 214-22-2780 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County death with the Maryland Director marked other than "natural", or items 23a or 28a-f s matic event, the Medical Examiner must be notified 1 Yes 2 X No Cockeysville Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21030 10701 Cardington Way Apt. 202 USA Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian. Armed Force Black, White, etc. 1 Yes 2 X No
If Yes, Give
Year or Dates. þ 1 Never Married 2 X Married permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Food Service Waitress Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alma Marie Rogers Haslup G. Hagerman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21030 <u>.s</u> 10701 Cardington Way Apt. 202 Cockeysville, Derald N. Jendersee/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State November 3 Dulaney Valley Memorial Gardens Important: If it any injury or o 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Timonium, MD 2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundral Salin Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Road Timonium, MD 21093 Lionsee Inc. Flagle Michael J. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician. disease or condition resulting in death) Medical ue to (or as a consequence of): Examiner Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury de that initiated events the burial-trai Due to (or as a consequence of): resulting in death) Last physician Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 🗌 Yes Division of Vital Records, 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? autopsy performe cate has page 2 s his certificate h Il director, page 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ျှ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) this Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred After 5 Pending work' 1 🗌 Yes 2 🗌 No ithin 24 hours after death.

the Funeral Director: Aformpleted filled in by the fu Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practiciner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifie (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar (Month, Day, Year)

NOV 0 4 2010

of death (Item 23a) (Type, Print)

32. Registrar's Signature

Andrew Frank
10-08337 Joyce
Unk Unk

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month 0305 hrs Medical Examiner November 1, 2010 Andrew Frank Joyce 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) 500 West Mosher Street **Baltimore** If Under 1 Year I if Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. Director July 10, 1987 Country) 216-27-1013 1 X M 23 2 F Vrs Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits iny 10a State 10b. County 1 Yes 2 X No 'natural", or items 23a or 28a-f show Examiner must be notified at once, Ellicott City Howard Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho
rijury or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 3605 Horned Owl Court 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 X Never Married Yes Specify: White Yes, Give Year 1 Yes 2 X No specify: 4 Divorced 3 Widowed Š 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Towing Tow Truck Driver 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rosemarie Zerhusen Michael Joseph Joyce 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3605 Horned Owl Court; Ellicott City, MD 21042 Father Michael Joyce 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State crematory or other place) Ellicott City, MD 11/4/2010 St.John's Cemetery Donation 5 Other Specify 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Lic-ns. 236. Part I. Enter the disease or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line Medical Death a. Gunshot Wound of Chest Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate causa. Enter Underlying Cous Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical physician a UNPENDED AMENDED certificate be Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the Day 3 Ectopic pregnancy Year attending I Live birth Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) 5 The law requires that the death Yes 2 No 9 Unknown Unknown detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. þ Yes 2 ✓ No 3 Probably 4 Unknown Completed Records, 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of has performed' death? 1 🗸 Yes 2 No ✓ Yes 2 No 26.Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be examiner? Hospital: 1 Inpatient 2 Other 1 Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 DOA this 1 Yes 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? After 27. Manner of Death Certification: Subject shot Nov 1, 2010 0235 hrs Natural 1 ✓ Yes 2 No Director: din by the fi Pending Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) 500 West Mosher Street, Baltimore, Md. determined (Specify) Local Street 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number November 1, 2010 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Laron Locke MD. Assistant Medical Examiner 31. Date filed (Month, Day, Ye 2. Registrar's Signa State 4 2010 Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34484 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November RUTH MAY KLOCH 2010 11:15 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death MANOR CARE HEALTHCARE-RUXTON Towson Baltimore County 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💢 F July 25 Year 1916 Marvland Director 214-03-4540 94 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 🗆 Yes 2 No Maryland Baltimore County Parkville 10f. Zip Code 10g. Citizen of What Country? by Funeral 7400 Park Drive 21234 USA ral", or items ? Examiner mus 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Completed 3 X Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Librarian Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ည Herbert Dawson Barnes Rose May Atkinson traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) G. Charles Kloch 507 Goucher Blvd., Towson, Maryland 21286 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State in ii 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) permit. Page Department o Important: If any injury or Baltimore, Maryland Green Mount Crematory 11/3/2010 Signal Full S. vi. Accorded www.

Martin D. Lawson MITCHELL WIEDEFELD FUNERAL HOME. 6500 York Road, Baltimore, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ DAMEN disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the human thrown. that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: es, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4K Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 120047675 of person who completed cause of death (Item 23a) (Type, Print) Name and address OCLEVE DILVE, Site 311. towcov, MD. 21204 Ve OMALLENINO

DHMH 17 Rev 7/2009

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Howard Warren Kinslev Medical November 2010 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Berlin Nursing and Rehabilitation Center Berlin Worcester 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 4, 1924 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country) Maryland 1 🕅 M 2 🗆 F Months Days Hours Min. 216-12-2655 Director Yrs Usual Residence of Decedent 10b. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 No Maryland Worcester Ocean City 10e. Street and Number ö 10g. Citizen of What Country? Funeral 23a 216-8 North Heron Drive 21842 U.S.A permit. Page 1 and 2 should be filed wirthin 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mione. 11, Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 X Married Completed by Yes 2 No nsley, howard timore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Divorced Year or Dates. 1943–46 Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) 4 years Elementary/Seconday (0-12) Contracts Manager Government Contracts Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Reuben Clark Kinsley Lizetta Lang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Camilla S. Kinsley (wife) 216-8 North Heron Dr. Ocean City, Maryland 21842 Kinsley Baltimore, I 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carrison Forest Veterans Cam. 11-9-10 Owings Mills, Maryland 21. Signature of Funeral Service Licensee Mitchell Wiedefeld Funeral Home, In 6500 York Road <u>Baltimore</u>, <u>Maryland</u> 23a. Part 1. Enter the usease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ End Stage Alzheimer's Dementia disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Cause (Disease or linjury Be Completed by Physician/Medical Examiner Due to (or as a consequence of) that initiated events Due to (or as a consequence of) resulting in death) Last P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery Fctopic pregnancy Hospital or Attending Physician: The law requires that the death in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year 4 Pregnant a Pregnant at time of death 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed' 1 ☐ Yes 2 ☐ No Yes 2 V N **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 X Nursing Home 5 Residence 6 Other (Specify) ပ 1 Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 XNatural 5  $\square$  Pending 24 hours after death. Funeral Director; Af 2 Accident
3 Suicide
4 Homicide 1 🔲 Yes 2 🗌 No Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 XCertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month. Dav. Year) R 135131 November 1, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Pennie Savage,

NOV 0 4 2010

31. Date filed (Month, Day, Year,

CRNP

32. Registrar's Signatur

9715 Healthway Dr, Berlin,

MD

21811

10-07951 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Jerry Lee Klingenhofer State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day October 16, 2010 1418 hrs Medical Examiner Jerry Lee Klingenhofer 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Aberdeen Harford 5. Social Security NumberUNK 6. Sex If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Unk 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Director July 13, 1959 51 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County 1 Yes 2 X No "natural", or items 23a or 28a-f show Examiner must be notified at once. Aberdeen MD Harford permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21001 USA 220 Garner Drive 11. Marital Status unk Funeral 12. Was Decedent Ever in U.S. Armed Forces? UNK 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Yes 2 No Specify: white If Yes, Give Year Yes 2 X No specify: è 16a. Decedent's Usual Occupation (Give kind of work done UNK 16b. Kind of Business/Industry UTIK 15. Decedent's Education (Specify only highest grade completed) pleted during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) traumatic event, the Medical unk 17. Father's Name (First, Middle, Last) unk 18.Mother's Name (First, Middle, Maiden Surname) UNK Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 111 Penn Street; Baltimore, MD 21201 O.C.M.E. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery. 20c. Location - City or Town, State crematory or other place) Burial 2 Cremation 3 Removal from State Donation 5 Other Specify: in state Signature of Funeral Service Ronal d 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street; Baltimore, MD 21201 I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician e. List only one cause on each line Between Onset and /Medical Death a. Contact Gunshot Wound of Head Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed and sician/Medical UNPENDED AMENDED attending physician or use as the burial Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Day Year 2 past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ö ठ 1 Yes 2 V No 3 Probably 4 Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) of Vital Be Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 🗸 Other: Scene ER/Outpatient 3 DOA After this 1 Yes 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Oct 15, 2010 Subject shot self 1418 hrs Natural Pending Division 1 Yes 2 V No Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 220 Garner Dr. Aberdeen, MD determined (Specify) Mobile Home Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the

DHMH 17 Rev 1/2001

State

Registrar

Marke

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

and manner stated.

Assistant Medical Examiner

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

29b. Şignature and title of certifier

Margarita Korell MD.

NOV 0 4 2010

31. Date filed (Month, Day, Year)

October 17, 2010

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ William Alston Kelly October 2010 :35 P MMedical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Gilchrist Hospice Towson Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth Funeral Min 1 ₺ M 2 🗆 F sept 24, Year 957 MaryTand 53 Director 216-68-4184 Yrs. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21202 818 E. Eager Street 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Completed by Specify: black 1 ☐ Yes 2 🙀 No Specify: 3 Widowed 4 K Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) custodian YMCA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William A. Kelly Sr. Shrley Essex 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 414 N. Bradford St; Baltimore, MD 21224 Rodney Kelly - son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses Wag 22. Name and Address of Facility State Anatomy Board /Director 655 W. Baltimore Street; Baltimore, MD 21201 23a. Part 1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure, List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ METASTATIC LUNG CANCOR disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be attending p for use as t IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 Yes 2 No signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by INFECTION 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? 2 I No 1 Yes 25. Was case referred to predical Be 26. Place of Death (Check only one) Hospital Other: 2 4 No 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Box 68760 Records, To the Hospital or Attending Physician: The law i within 24 hours after death.

To the Funeral Director: After this certificate has E completed filled in by the funeral director, page 2 s Division of Vital

Baltimore, Maryland 21215-0036

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER HARLES KISSINGER 1:50 AM THOMAS 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE HARBOR HOSPITAL If Under 1 Year If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Dec. 20, 1**X**☐M 2 ☐ F Year)193<u>5</u> 74 Months Hours Pennsylvania 171-28-6687 Director Usual Residence of Decedent 28a-f shov 10a. State 10d. Inside City Limits 10c. City. Town or Location Examiner must be notified at **Funeral Director** MDBaltimore Baltimore 1 ☐ Yes 2 No 10e, Street and Number 10f. Zip Code ō 10g, Citizen of What Country? items 23a 21227 939 Regina Drive United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2X No Black, White, etc. o. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: White If Yes, Give Year or Dates "natural", 3 X Widowed 4 □ Divorced Completed of Health and Mental Hygiene.
item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Warehouseman General Electric Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be fill ment of Health and Mental ant: If item 27 is marked ပ Levi Jacob Kissinger Viola Regina Rage 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amanda Richards -daughter 939 Regina Drive., Baltimore, MD 21227 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Memorial Park permit. Page 1 Department of Important: If it any injury or o Burial 2 Cremation 3 Removal from State 11-3-2010 Conation 5 Other (Specify) Elkridge, MD 22. Name and Address of Faciliambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final SEPSIS Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) METASTATIC LUNG CANCER Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical EUKEMIA Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 💢 Probably 4 ☐ Unknown To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🔀 No Yes 2 🛚 No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 🔀 No 1 XInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Physi within 24 hours after death. To the Funeral Director: After this of completed filled in by the funeral din after death.

Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🗷 Natural 5 Pending 1 🗌 Yes ☐ Accident ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier rain! RES-001 OCTOBER 27,2010 M.D

State Registrar

DHMH 17 Rev 7/2009

STREET, BALTIMORE, MD-21225

3001 S. HAMOVER

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ADITYA SAIMI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34489 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 2010 ar 8:00 P M Shirley Irene Kurtz Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death South Ellamont Street Baltimore City 1617 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth Funeral 9. Birthplace (State or Foreign 1 □ M 2 🗐 Country Maryland Months Days Hours August 9, Director 212-28-1660 79 193 Usual Residence of Decedent show 10a. State should be filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 √ Yes 2 □ No MDN/A Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1617 South Ellamont Street 21230 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status Race - American Indian, Armed Forces?
1 ☐ Yes 2 🕅 No
If Yes, Give If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify:White 1 ☐ Yes 2 X No Specify: "natural", 3 XWidowed 4 ☐ Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant: If item 27 is marked other than Baltimore City Elementary/Seconday (0-12) College (1-4 or 5+) 12 Police Officer Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Lloyd В. Emma Irene Kroneberger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Irene Kurtz-Daughter <u>1617 South Ellamont Street.</u> Baltimore Maryland 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Loudon Park Cemetery Nov.5,2010 | Baltimore MD 4 Donation 5 Other (Specify) ature of Fundamental Service Licenses 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Road, Lansdowne MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final 2 hermer Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner awartielly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year the 9 Unknown 9 Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ ma (nour ishment 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has b page 2 s performed Yes 2 certificate 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) After this Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: injury 5 Pending Accident Suicide Investigation the Funeral Directory of filled in by the Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D51018 nomo

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

NOV 0 4 2010

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Douglas Pinto, MD 242 Benson Ave. Bultimare MD 21227

Records, P.O. Box 68760.

Baltimore, Maryland 21215-0036

the death certificate be executed Division or Vital After 1 Attending within 24 hours after death

To the Funeral Director:
completely filled in by the ö To the Hospital within 24 hours at To the Funeral C

Tioniode Building, etc. (opecity)		ny or rown, state)
29a. Certifier (Check only one)  Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basis of examination and manner stated.	ige, death occurred at the time, date and place, and d and/or investigation, in my opinion, death occurred at	ue to the cause(s) and manner as stated. the time, date and place, and due to the cause(s)
29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
PHYSICIAN	00064533	11/22/2010

28f. Location (Street and Number or Rural Route Number,

CIERIATRIC

21215

State Registrar

Medical

BARATUNDE 31. Date filed (Month, Day, Year) 0 4 2010

3 ☐ Suicide

6 Could not be

AJANI

mo

28e. Place of injury - At home, farm, street, factory, office

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEVINDALE -MEBREW CIERLE AVE - BALTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death NOVEMBER 1, 2010 Physician/ 7:00 P M KANEVSKY BLUMA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE BALTIMORE MILFORD MANOR NURSING HOME 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** Min. Months Days Hours 0372571921 Country) 1 □ M 2 ⋤ F UKRAINE 89 Director 127-78-8704 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State Examiner must be notified at Director 1 X Yes 2 No MD N/A BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 5 10e. Street and Number 23a Funeral USA 5715 PARK HEIGHTS AVENUE, APT. 810 21215 "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give 11. Marital Status Black, White, etc. should be filed within 72 hours after on and Mental Hyglene. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: WHITE 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical I. 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) QUALITY CONTROLLER GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည MINOLYA KANEVSKY YANKEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5715 PARK HEIGHTS AVE., APT.810, BALTIMORE, MD 21215 SERGEY PORYADOCHNY/HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/03/2010 OWINGS MILLS, MD HAR SINAI CEMETERY 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 21208 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, Interval Between shock, or heart failure. List only one cause on each line. Opset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ORGESTIVE Medical Due to (or a / a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No Year Month Day Pregnant at time of death completed filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed/P death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 D Nursing Home 5 Residence 6 Other (Specify) ပ္ 27. Man er of Death 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: injury Natural 5 Pending 1 Yes 2 No Accident Investigation Could not be 3 Suicide 4 Homicide Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 7/2009

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and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MARY GARVEY LIGHT 10 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death imore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Hours 1 □ M 2 🔀 F (Month, Day, Year) 05/18/1930 218 26 2083 MARYLAND 80 Director Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland injury or other traumatic event, the Medical Examiner must be notified at Director BALTIMORE MD ROSEDALE 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? or items 23a Funeral 1504 SELING AVENUE 21237 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 72 hours after WHITE 1 Yes 2 XNo Specify: Specify: "natural", 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) be filed within PARA LEGAL LEGAL AID INC. is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental ပ THOMAS GARVEY BURKE MARY permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTIMORE, DONALD G. LIGHT/HUSBAND 1504 SELING AVE MD 21237 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/03/10 OAKLAWN CEMETERY BALTIMORE, 22. Name and Address of Facility 21. Signature of Funeral Service Licensee CVACH/ROSEDALE FUNERAL HOME AVE BALTIMORE. CHESACO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ o cardial Acuic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner pertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine (or as a consequence of): Due t physician and s the burial-trans Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 tending ph IE FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day 1 Yes 2 Le 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No ဂ္ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred injury Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death open at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioners to the best of my manufactory weath occurred at the time, date and close and due to the cause(s) and manner as stated. (Check univ or 29b. Signature and title of certifier 29c. License number 29d. Date signed (Mghth, Day, Year) D54702 30. Name and address of person who complete se of death (Item 2 a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

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Registrar's Signat

NOVEILO

Nona

31. Date filed (Month)

FRANKLIN SQUAJE

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 05.18PM Loris Leslie OCTUBER /Medical 2010 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Future Care Irvington Baltimore N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Monthe | Days | Hours | Min. (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) **Funeral** 239-36-9423 1 M & F Days 84 Director Oct 26,1926 NC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Evanriant mast bu multiled at once. 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits MD N/A Baltimore Director ★□Yes 2□No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 N. Smallwood St Apt. 203 USA 21223 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify: þ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) St. Agnes 12th <u>2Yrs</u> Nurse Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willie Holden, Sr. Easter Carmichael 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Leslie/Husband 2 N. Smallwood St #203 Balto., MD 21223 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ASbutus Mem Park 10/5/10 Arbutus, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Beverly D. Cromartie F/S 21. Signature of Funeral Service Licenses 2700 Edmondson Ave. Balto., MD 21223 . Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final INFECTED **Physician** DECUBITUS ULCER FEW WEEKS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any uning to try cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a consequence of attending physician and for use as the burial-transit The law requires that the death certificate be execute P.O. Box 68760, resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ₺ lo been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, <u>8</u> MALNUTRITION, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? cate has page 2 s autopsy performe certificate 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 X Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) NOVEMBER 1, 2010 D0062634 30. Name and addr of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

MATERN

NOV 0 4 2010

31. Date filed (Month, Day,

AWAN

AN MO 2. Registrar's Signature 10796 HICKORYRIDGE RD COLUMBIA MD 21.44

10-08330 David Leeson

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 3449 State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar			Certific	ate of	Death			R	eg. No.		
Physici Medical Exam	an/ iner	Decedent's Name (First, Midd	Dav:	id A. Le	eson					Date of Dea Month October 3	Day 31, 2010	Year	3. Time of Death 1901 hrs
		4a. Facility Name (if not institution Baltimore Washington		4	b. City, Town, or Glen Burnie		of Death	4c. County of Death Anne Arundel					
Funeral Director		5. Social Security Number 220–94–6018	6. Sex 7. Age (in yrs. last b				If Under 1 Yea Months Day		_				thplace (State or Foreign puntry)
Aaryland 28a-f show any 1at once.	or.		altimore	10c. (	City, Town	or Locatio	Reiste	rstown	1				10d. Inside City Limits 1 Yes 2 No
the Mary a or 28a-	Director	10e. Street and Number 107 Westminster P	ike				10f. Zip Code 21136			1	10g. Citizen of U.S		ntry?
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Heath and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	by Funeral		Armed F  1 Yes  Vorced If Yes, Give Ye or Dates:	orced If Yes, Give Year			13. Was Decedent of Hispanic Origin? ( Spelf Yes, specify Cuban, Mexican, Puerto I  1 Yes 2 No specify:				Specia	hite, etc. Whi fy:	
MD 21215-0036 12 should be filed within 72 hours af th and Mental Hygiene 127 is marked other than "natural umatic event, the Medical Examin	Completed	15. Decedent's Education (Spe Elementary/Secondary (0-12) 12		1-4 or 5+)	d) 16a.		s Usual Occupai st of working life ger				16b. Kind of Hotel		Restaurant
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Be	17. Father's Name (First, Middle	Ernest	Leeson					_ ,	First, Middle, I	Maiden Surna N	me)	
MD 21 nd 2 should b alth and Mer m 27 is mar	٢	19a. Informant's Name/Relations Mary Gans-Leeson (			- 1.0		Address (Stree						e, Zip Code)
		20a. Method of Disposition  1 Burial 2 Cremation  4 Donation 5 Other S	pecify:	rom State	cremat	aven l	Memorial		11/4		Glen B	•	Town, State
Balti permit. Departu Import		21. Signature of Funeral Service	want	2		303,	me and Address gee Henss L Falls Ro	oad B	alto.	MD = 212			
Physician xaminer		23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease	on each line.				e mode of dying, .cated b					heart	Approximate Interval Between Onset and Death
		or condition resulting in death)  Sequentially list conditions,	Due to (or as a										
9.	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a Due to (or as a									-	
executed an and all - transit		X UNPENDED	d	0.7			11/10/1	0 77					
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and implietly filled in by the funeral director, page 2 should be detached for use as the burial - transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 Live t	outcome or pointh nant at time o	oregnancy 2	Feta	11/18/1 al death 3   er (Specify)		pregnanc	:y	23d. Date Month	of delivery	/ Day Year
P.O. Besthat the degree by the detached for	by Phy	Part II. Other significant condit	9 Unkn		ot resulting	g in the un	derlying cause g	given in Pa	rt 1.		_		the cause of death?
Division of Vital Records, P tal or Attending Physician: The law requires t rs after death.  The Director: After this certificate has been sign led in by the funeral director, page 2 should be or	Completed				-					24a. Was	an 24l osy rmed?	o. Were au	topsy findings available completion of cause of
ital Recions: The secrificate rector, page		25. Was case referred to medica					26 Place	of Death	(Check on				
Vita hysicia this ce	To Be	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	<b>✓</b> ER/O	utpatient	3 DOA	Other 4	Nursing I	Home 5	Residence 6	6 Other	
ion of tending Pl eath. or: After the funera		27. Manner of Death  1 X Natural 5 Pence 2 Accident Invest		of Injury n, Day,Year)	28b. 1	Time of Inj		ry at Work res 2		Bd. Describe I	how injury occ	urred	
Division of Division of the Hospital or Attending Phentin 24 hours after death, or the Funeral Director: After Impletely filled in by the funeral	Certification:	3 Suicide 6 Coul			At home, fa	m, street	, factory, office b	uilding, et	c. 28	8f. Location (8 or Town, S		nber or Ru	ral Route Number, City
To the Hosy within 24 ho To the Fun completely i	Medical C		hysician: To the bearing miner: On the basis and manner s	of examination									
	M	29b. Signature and title of certifie		din			29c. Licens				29d. Date si		nth, Day,Year)
0x 600	1	30 Name and address of person Carol Allan, MD Ass	who completed causistant Medical			Penn S	treet, Baltime	ore, MD	21201				
St Regist	ate	31. Date filed (Month Day Year)	32. Re	egistrar's Sign	nature	V							

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				partment of Health and Mental Hygiene	
		e		ertificate of Death Reg. No. 2010 3449	5
	Physicia		1. Decedent's Name (First, Middle, Last)	2. Date of Death  Month October 23 2010 3:47 Pt	M
	Medic Examir		Miriam Lyons 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death  4c. County of Death	VI
			Prince Georges Hospital Center	Cheverly Prince Georges	
	Funeral Director		5. Social Security Number 6. Sex 7. Äge (In yrs. last birthday, 1 M 2 🖾 F 74	If Under 1 Year   If Under 24 Hrs.   8. Date of Birth   9. Birthplace (State or Foreign Months Days Hours Min.   Aug 31, 1936   9. Birthplace (State or Foreign Country) Unix	gn
			Usual Residence of Decedent		
	aryland a-f she fied at	ector	10a. State 10b. County 10c. City, Town or L	ocation 10d. Inside City Limit	
	or 28 e noti	ä	DC 10e. Street and Number	10f. Zip Code 10g. Citizen of What Country?	
	n with	Funeral Director	901 First St. NW; #222	20002 USA	
	r death or item iner n		11. Marital Status <b>unk</b> 1 Never Married 2 Married 1. Was Decedent Ever in U.S. <b>unk</b> 13	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.	
036	rs afte ral", c Exam	ed by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.	1 ☐ Yes 2 🗷 No Specify: Specify: black	
15-0	72 hou r "natu edica	Completed	(Give	edent's Usual Occupation unk skind of work done during most of working	
21215-0036	within 72 hours after death with the Maryland glene. ier than "natural", or items 23a or 28a-f sho is the Medical Examiner must be notified at		Elementary/Seconday (0-12) Unk  College (1-4 or 5+) Unk	DO NOT use retired)	
nd	filed vital Hyg	To Be	17. Father's Name (First, Middle, Last) unk	18. Mother's Name (First, Middle, Maiden Surname) unk	
Maryland	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	٦	10a Informatia Nama/Delationakia (Time Chint)		_
Ma	d 2 shou alth and 27 is m	ij	1	ing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ol Hospital Dr; Cheverly, Maryland 20785	1
Baltimore,			20a. Method of Disposition 20b. Place of Disp		
ţim	t. Pag tmer ttant rijury		4 □ Donation 5 ☒ Other (Specify) In State		
Bal	permi Depar Impo any Ir		21. Signatur Rin ral Strice Lensage Wade Trector	2. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street; Baltimore, MD 21201	
			23a. Part 1. Enter the disease, or/complications that caused the death. Do not en shock, or lifer failure. List only one cause on each line.	ter the mode of dying, such as cardiac or respiratory arrest,  Approximate	
	hysician/	ğ 10	Immediate Cause (Final disease or condition	Cardiac arry Wwa Interval Between Onset and Death	1
	Medical Examiner		resulting in death)  Due to (or as a consequence of):	San Rand Nices	
-		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  Due to (or as a consequence of):	Tage Kenas Disease	
	and transit	Examiner	Cause (Disease or linjury that initiated events resulting in death) Last  Due to (or as a consequence of):	Hypoventilalie Syndiane	
0	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	calE	resulting in death) East	, ,	
Box 68760	ificate ng phy as the	Physician/Medical	IF FEMALE:		
9 X	th cert ttendir or use	ian/I	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 Live Birth 2 Fetal death 3	Ectopic pregnancy 23d. Date of delivery	108
B	he dea y the a ched fi	nysic	1 ☐ Yes 2 No 4 ☐ Pregnant at time of death 5 g ☐ Unknown 5	Other (specify) Month Day Year	
P.O.	requires that the de: been signed by the s should be detached	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?	
rds,	equires een siç nould b	eted		1  Yes 2 No 3 Probably 4 Unknow	/n
Division of Vital Records,	The law rate has b	Completed		24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?	
<u> </u>	sician: The law is certificate has birector, page 2 s		25. Was case referred to medical	performed? death?  1  Yes 2 No 1 Yes 2 No  26. Place of Death (Check only one)	
Zi:	hysici his cer I direc	မ	examiner? 1 ☐ Yes 2 📉No Hospital: 1 ☐ Inpatient 2 💢 ER/Outpatie	nt 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)	
n of	nding Physician: 1 th. : After this certifica : funeral director, p	ate:	27. Manner of Death  1 Natural 5 Pending  28a. Date of injury (Month, Day, Year) injury	f 28c. Injury at work?  M 1  Yes 2  No	
isio	# 5 6 6 6	Certificate:	2		-
<u>&gt;</u>	ital or ars afte ral Dir led in l		building, etc. (Specify)	City or Town, State)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	(Check 2 <sup>nd</sup> Medical Examiner: On the basis of examination and/or investigation (Check 2 <sup>nd</sup> Medical Examiner: On the basis of examination and/or investigation).	occured at the time, date and place, and due to the cause(s) and manner as stated. stigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner starting the cause of the	ted.
	To the within To the compl		only one) 311 Certifying Nurse Practioner: To the best of my knowledge, 29b. Signature and title of certifier	death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29c. License number  29d. Date signed (Month, Day, Year)	$\exists$
D			Jourch Rom	14 D0065108 10/27/2010	)
			30. Name and address of person who completed cause of death (Item 23a) (Type, Pouneh Nouri, MD 106 IRVING ST	NW Ste 201 Wash. DC 20010	
	Stat	e	31. Date filed (Month, Day, Year) 2. Registrar's Signafure		
	Registra	r	MANA A FOIL LEMEN D. Man	<b>√</b> start	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #±418 Per FH G909 11/05/10 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 330 AM TAYLOR MAE MACLIN 29 2010 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bactimore FRANKLIN SQUARE HOSPITAL Rosedale If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day, Year) 08/13/1953 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Min. 1 □ M 2🛛 F 229 74 8950 57 Yrs. Director VIRGINIA Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show d other than "natural", or items 23a or 28a-f showevent, the Medical Examinar must be notified at MD BALTIMORE NOTTINGHAM 1 ☐ Yes XXNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8011 RIDGETOWN DRIVE 21236 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc.

Black within 72 hours after 1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Married 2 ☐ Married Machin Taytor altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: WIIIIE þ 3 ☐ Widowed 4 ☑ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) IN PLANT MANAGER U.S. POSTAL SERVICE Pages 1 and 2 should be filed 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) Be TAYLOR POWELL Wilson ALSTON SR. ADELINE ပ 19a. Informant's Name/Relationship (Type. Print) DAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TIFFANY A. MACLIN BROWN 8011 RIDGETOWN DR BALTIMORE, MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State GARDENS OF FAITH 11/04/10 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee 1211 CHESACO AVE BALTIMORE, MD 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician UNKNOWN TYPE Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. In the district Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an page 2 s autopsy performed? Yes 2 No 1 ☐ Yes filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) October 29, 2010 D63054 mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 21237 MO, MO 9000 Franklin Square Baltmore, Registrar's Signature 4 2010 State

Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Lillian Irene McDorman 11:42 Medical October 0 2010 Α 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Dove House Carroll Westminster 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 TE Hours Director 215 22 5424 96 Virginia Usual Residence of Decedent filed within 72 hours after death with the Maryland al Hygiene. A other than "natural", or items 23a or 28a-f show 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Carroll Maryland Hampstead 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4801 Upper Beckleysville Road 21074 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: 3 XWidowed 4 Divorced Completed Year or Dates White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 8th College (1-4 or 5+) the Factory Worker Christmas Ornanments Be injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F William Miller Pearl Clam 1 and 2 should by if Health and Mer item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JoEllen Hammond / Daughter 1431 Thies Drive Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State . of 1 😾 Burial 2 🗆 Cremation 3 🗆 Removal from State permit. Page Department o Important: If any injury or Glen Haven Mem. Park 11/01/2010 4 Donation 5 Other (Specify) Glen Burnie, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Final Onset and Death RESPIRATORY FAILURE, Pulmonary Emboli Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Cholecustitis Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed after death. Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day ☐ Yes 2 L ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Division of Vital Records. 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed Yes 2 2 🗆 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 🗌 No Investigation Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital o within 24 hours af To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier MD D0061558 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STONER AVE, STE 305, WESTMINSTERIM PARIKH MD 295 31. Date filed (Month, Day, Year) State 4 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend #18, 20a-c, 22, per Fh g908 11/3/10 TT

AMEND MAY Property of Health and Mental Hypiens AMEND MEMPINE, per FH, #4a, per FHY S, G9Mental Hypiens AMEND MEMPINE. Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 24 2010 Mae Mencher October /Medical 12:15 РМ 4a Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death <del>8701</del> International Drive #623 Silver Spring Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, June 5, 9. Birthplace (State or Foreign Country)
New York Months Days Hours Year) 1919 Director 057-10-0287 91 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside Cify Limits ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Evantine rougt be notified at Director Montgomery Silver Spring 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8701 International Drive; #623 20906 Funeral USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces?
1 ☐Yes 2 ☑ No
If Yes, Give
Year or Dates; 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or by 1 ☐ Yes 2 No Specify: Specify: White 3√ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, It a Ma Elementary/Secondary (0-12) College (1-4or 5+) 12 social worker City of New York 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Berman Molly Perotsky 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven Mencher - son 7203 14th Avenue; Takoma Park, Maryland 20912 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 11/13/2010 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4□Donation <del>5₺Other (Specify)</del> in state Final Journey Cremation Woodbine, Cremation se for Esapo Box 19413 Board Mary 1 20203 e of Funeral Service Lie 655 W. Baltimore Street; Baltimore, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on a ch line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Secure fully list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, signed by the attending physician be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4 ☐ Pregnant at time of death 9 ☐ Unknown Day 5 ☐ Other (specify) 9 Unknown the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an was a... autopsy performed? Ves 2 No certificate 1 □ Ýes 1 ☐ Yes 2 100 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \( \sum \) Nursing Home Certification: To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Nesidence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ∏ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Funeral D 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier (Check only one) the the 29b. Signature and title of cer 29d. Date signed (Month, Day, Year) 30. Name and address of person cause of death (Item 23a) (Type, 31. Date filed (Month, Day, Year) State Registrar's Signature NOV O Registrar

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State of Maryla State Registrar  1. Decedent's Name (First, Middle, Last)	•	rtificate of L		,	leg. No.	010	34499	
Physici /Medi		Gertrude McCoy				October	19 <sup>ay</sup>	20°10	11:18 P M	
Examir		4a. Facility Name (If not institution, give street and number)  Morningside Assisted Living		4b. City, Town, or Waldorf				inty of Death arles		
Funeral Director		5. Social Security Number  241-40-6299  6. Sex 1 □ M 2 ☒ F  84	rs. last birthday) 4 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day May 31,	1926	9. Birthp Court Nort	lace (State or Foreign hry) Carolina	
Maryland a-f show	ctor	Usual Residence of Decedent           10a. State         10b. County         10c.           MD         Charles	City, Town or Loc Waldorf	cation				1	0d. Inside City Limits 1 ☐ Yes 2♣ No	
th with the 23a or 28 int be no	Funeral Director	10e. Street and Number 12142 Pantickett Lane	10f. Zip Code 20602			10g. Citizen USA	og. Citizen of What Country? USA			
s 1 and 2 should be filed within 72 hours after death with the Maryland items and Mental Hygiene. Items 71 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Problem Example change by Indianal and Indiana		11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Ever in Armed Forces?  1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	1	Was Decedent of His fYes, specify Cubar I □Yes 2⊠No	ecify Yes or No- Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify: black			
within 72 ho iene. <b>than "natur</b> re l'esice.	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)  1.2 College (1-4or 5+)	(Give	16a. Decedent's Usual Occupation (Give kind of work done during most of wor life. DO NOT use retired)  home health aide		ing		Sb. Kind of Business/Industry healthcare		
buld be filed with Mental Hygiene. arked other thar atic event, the fi	Be	17. Father's Name (First, Middle, Last) Eugene Dunn			18. Mother's Name Sudie B		Maiden Suri			
od 2 should atth and Metal Met	10	19a. Informant's Name/Relationship (Type. Print) Cheryl Dunn - niece	I					City or Town, State, Zip Code)		
permit. Pages 1 and 2 Department of Health is Important: If item 27 is any injury or other tra		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☒ Donation 5 ☐ Other (Specify)	20c. Location	ocation - City or Town, State						
permit. Departr Importa any inju		21. Sunth of Fineral Squice Scensor Virect	or <sup>22</sup>	Name and Address			-		MD 21201	
Physician /Medical Examiner	J.	23a. Part \ Enter the disease, or complications that caused the dishock, or heart failure. List only one cause on each limit disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate  Due to (or as a constitution).  Due to (or as a constitution).	, or y	Carcil		or respiratory ar	rest,		Approximate Interval Between Onset and Death	
Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rall director, page 2 should be detached for use as the burfal-transit	edical Examiner	Sequentially list conditions, if any, leading to Immediate cause. Entite Unidentlying Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a constitution of the constitutio								
the death certific by the attending p ached for use as i	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown  23c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time 9 □ Unknown	Ectopic pregnancy Other (specify)			23d.	Date of delive Month	ery Day Year		
w requires that the d sben signed by the should be detached	þ	Part II. Other significant conditions contributing to death but not	n in Part I.	23e. Did tobacco use contribute to the cause of death						
: The law rec cate has bee , page 2 shoo	Completed	Hyputension		24a. Was an autopsy fine prior to completion death?  1 □Yes 2 ▶No 1 □ Yes 2 □ N			mpletion of cause of			
Physician: The this certificate al director, pag	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 PNo Hospital: 1 ☐ Inpatient 2	ER/Outpatien	t 3 DOA Othe	26. Place of Death			Other (Specif	A55 3 3	
ne fte	ation: T	27. Manner of Death 1 Malatural 5 □ Pending (Month, Day, Year 2 □ Accident investigation	28b. Time of	28c. Injury Work'	at	me 5 ☐ Residence 6 ☐ Other (Specify)  28d. Describe how injury occurred				
To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - A building, etc. ⟨Spe	umber or Rura	al Route Number,						
he Hosp in 24 hou are Fune pletely fil	ledical	29a. Certifier (Check only one)  1  Certifying Physician: To the best of my large and manner stated.	ination and/or inv	vestigation, in my op	inion, death occur	red at the time,	date and pla	ce, and due to	the cause(s)	
To the within 2 To the comple	Me	29b. Signature and title of certifier  30. Name and address of person who completed cause of death (I	ND	29c. License	number 007601	0	29d. Date si	gred (Month,	Day, Year)	
<b>F</b>		30. Name and address of person who completed cause of death (I	tem 23a) (Type, F	Alfamon	+, wh	· 40 P	Corrs	, ive	20695-	
Sta		31. Date filed (Mohth, Pay Year) 32. Registrar's Signature 1	hature back	4						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Oct. 30, 2010 David Wayne McGee 9:50 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2739 Arbutus Avenue Baltimore Baltimore If Under 1 Year If Under 24 Hrs.
Adapthe Days Hours Min. 5. Social Security Numbe 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Maryland Months (Month, Day, Year) 2 213-64-4559 58 Director Aug. Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 No Baltimore MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ event, the Medical Examiner must be 23a Funeral 2739 Arbutus Avenue 21227 USA items ! 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces? 1 Yes 2 ANo Black, White, etc ō Completed by 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give "natural", 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. tant: If item 27 is marked other than 'iury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Home Improvement Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward McGee Jr. Mildred Lucille Wood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah McGee-wife 2739 <u> Arbutus Avenue, Baltimore MD 21227</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State Gedar Hill Cemetery Nov. 3,2010 Brooklyn Park MD 4 ☐ Donation ~5 ☐ Other (Specify) Signatule of Tune 22. Name and Address of Facility Ambrose Funeral Home of Lansdown 2919 Hammonds Ferry Road Lansdowne MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Completed by Physician/Medical Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) cate has been signed by the apage 2 should be detached a 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COPU COVENIC OPSINICTIVE Following Cause given in Part II. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🔀 No Hospital: ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this ( funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After work?
1 Yes 2 No 1 Natural 5 Pending s after death. 2 Accident
3 Suicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) the within To the 29b. Signature and title of certifier ucoon

State Registrar 30. Name and address of person who complete

31. Date filed (Month, Day,

**ORIGINAL** 

So. Hande

cause of death (Item 23a) (Type, Print)